

**NHS LANARKSHIRE**

**MATERNITY SERVICES STRATEGY**

**2008 – 2013**

**AMENDED VERSION 28<sup>TH</sup> AUGUST 2008**

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## **EXECUTIVE SUMMARY**

This short report has been prepared to inform NHS Lanarkshire Board of the intended strategic plan for Maternity Services 2008 – 2013, The strategy document sets out the current service and how this needs to change and develop to reflect National Policy and Contemporary Service Models.

### **1. INTRODUCTION**

#### **1.1 Background**

The most recent Maternity Services Strategy produced by NHS Lanarkshire was published in September 1995. Since that strategy was written, a great many changes have taken place in the provision of maternity care within Lanarkshire with concentration of inpatient maternity services at Wishaw General Hospital and increased midwifery input to ante natal care being the most notable. In view of these significant changes and publication of Government Policy documents for maternity services the need for a new Maternity Services Strategy has become clear. This strategy explores demographic data of women who access maternity services, describes current service provision, explains the drivers for change and presents the vision for maternity services in NHS Lanarkshire for the next 5 years.

#### **1.2 Current Service Model**

A traditional model of shared care is provided in a number of Consultant, Midwife and GP ante natal clinics in local health centres across Lanarkshire. In addition there are Maternity Day Assessment Centres in Wishaw General Hospital, Hairmyres Hospital, Airdrie and Lanark Health Centres and Early Pregnancy Services in Wishaw, Hairmyres and Airdrie. Inpatient maternity care is provided from 79 beds in Wishaw General Hospital and a small number of women choose to deliver at home. There is also a Level 3 Neonatal service in Wishaw with a total of 29 cots providing intensive, high dependency and special care facilities. This service provides services for babies born in Lanarkshire and also participates in the national cot bureau for neonatal care.

### **2. DRIVERS FOR CHANGE**

#### **2.1 National / Regional Framework**

The Framework for Maternity Services (2002), the Expert Group on Acute Maternity Services (2003) and NHS QIS Standards for Maternity Services (2005) set out Government Policy for maternity services in Scotland. These documents describe standards for maternity care which require changes to current service provision. In particular introduction of midwife as the lead professional for low risk women, introduction of routine CUBS and anomaly scanning and changes to the organisation of early pregnancy services.

Changes to service provision in neighbouring Health Board areas and recommendations from the Ministerial Action Group for Maternity and Neonatal Services may have an impact on maternity and neonatal services in Lanarkshire. It is therefore imperative that NHS Lanarkshire continues to engage in discussions to ensure that services are delivered within a national and regional context.

## **2.2 Demographic Data**

The total number of births to women resident in Lanarkshire has fallen over the past 25 years with a small rise being experienced 4-5 years ago which has been sustained since that time. This is consistent with the trend in Scotland overall. Census information reveals that there is a higher than average proportion of women aged 15-44 years in Lanarkshire within the most deprived groups and that the incidence of low birth weight and premature births is higher in Lanarkshire. The incidence of drug abusing mothers has also risen over the past five years. Obstetric intervention rates are consistent with national trends.

## **2.3 Workforce**

Implementation of Modernising Medical Careers, European Working Time Directives and other professional influences has had a significant impact on workforce planning within maternity and neonatal Services. It is therefore necessary to undertake a detailed review of the medical, midwifery and nursing workforce and to implement new roles to ensure that a sustainable, safe and effective service can be maintained in the future. Within neonatal services it is proposed that the role of Advanced Neonatal Nurse Practitioner (ANNP) is developed. This role will incorporate medical and nursing management of neonates and their families and will support the first receiving medical rota with potential for development to participation in the middle grade rota. Additional Consultant Neonatologist resource will be required for training, supervision and development of these practitioners.

## **2.4 Health Promotion**

The public health challenges of Lanarkshire are particularly important in relation to maternity services. The determinants of health status in adulthood begin in pregnancy and early life. Maternal smoking levels remain resistant to change and there is an increase in the number of mothers who abuse drugs. Breastfeeding rates are low at 37.8% when compared to a national rate of 53.1% at 5-7 days, and 24.86% in Lanarkshire at 6-8 weeks compared to a national rate of 36%. It is therefore necessary to enhance the public health role within maternity services.

## **3. FUTURE SERVICE MODEL**

Following a review of current services and drivers for change described above the following recommendations are made for future service provision. It should be noted that this strategy has been developed over a period of time. A view has been taken that recommendations which were not implemented by 1<sup>st</sup> January 2008 would be included in the strategy. There are therefore some recommendations described within the strategy that have been partially implemented within an agreed financial framework.

### **3.1 Key Recommendations**

Key recommendations within the strategy are:

- To further develop early pregnancy services on the Wishaw site to provide a dedicated service for the diagnosis, medical and surgical management of miscarriage.
- Midwife led care for low risk women should be implemented in line with the Keeping Childbirth Natural and Dynamic (KCND) national programme.
- Scottish Women Held Maternity Records should be implemented and audited in line with recommendations in NHS QIS Maternity Standards

- Respond to CEL published in July 2008 with regard to the implementation of Combined Ultrasound and Biochemical Screening (CUBS) in the first trimester of pregnancy.
- Implement routine Anomaly Scanning in the second trimester of pregnancy.
- Implement and evaluate a triage and assessment area within the maternity unit.
- Implement NHS Lanarkshire breast feeding strategy and achieve full WHO Baby Friendly Status.
- Enhance the public health role of the midwife and involvement of maternity services in strategy development for breast feeding, smoking cessation, substance misuse, domestic abuse and teenage pregnancy.
- Continued implementation of the expansion of the neonatal unit cot base including creation of a transitional care area to ensure that neonatal care can be provided locally for all babies born in NHS Lanarkshire and continued participation in the national cot bureau.
- Develop the workforce in maternity and neonatal services to take account of the impact of Modernising Medical Careers and feedback from the Nursing and Midwifery Workforce and Workload Planning Project.
- Review and strengthen public engagement and involvement in maternity services and engage in national discussion relating to Maternity Services Liaison Committees.

### **3.2 Financial Framework**

The financial framework within which this strategy has been developed is summarised in section 9.5 of this document. It should be noted that funding streams have been identified for all recommendations which require investment.

## **4. CONCLUSION**

This strategy has been developed in partnership with service users, staff representatives and other key stakeholders. It provides a clear vision for maternity services from 2008 -2011 which ensures that NHS Lanarkshire will continue to provide a safe, effective and innovative service to women and their families.

The NHS Lanarkshire Board is asked to;

- Approve the strategy document
- Delegate the authority for implementation to the Acute Divisional Management Team where this can be achieved within existing revenue resource limits
- Call for future progress reports against the key recommendations as summarised in section 9.5.

## **INTRODUCTION**

### **1.1 Previous Maternity Services Strategy**

The most recent Maternity Services Strategy produced by NHS Lanarkshire was published in September 1995. At that time births to Lanarkshire residents took place in two units, Bellshill Maternity Hospital and the William Smellie Unit at Law Hospital, Carluke. In addition a small number of births took place at home. A significant minority (30%) of births occurred elsewhere, principally at Rutherglen Maternity Hospital in Glasgow and at Glasgow Royal Maternity Hospital.

The key thrust of that strategy was the promotion of choice for pregnant women in two key areas, namely antenatal care and in the type and location of birth. Emphasis was also placed on the provision of clear quality standards on the promotion of healthy pregnancies and on a further reduction of the perinatal mortality rate. It was acknowledged that there was predicted to be a continuing decline in the number of births in Lanarkshire over the next decade and that there was uncertainty surrounding the future of Rutherglen Maternity Hospital. An Option Appraisal Group was therefore established to examine the possible provision of maternity beds in Lanarkshire in the future. At that time no specific recommendations were made about the future provision of maternity beds within hospitals in Lanarkshire.

### **1.2 Updating the Maternity Services Strategy**

Since that strategy was written, a great many changes have taken place in the provision of maternity care within Lanarkshire. Most obviously, both Bellshill and the William Smellie maternity units have closed and all hospital maternity beds are now in a single maternity unit incorporated within the recently built (2001) Wishaw General Hospital. The predicted closure of Rutherglen Maternity Hospital took place in 1998 and this has increased the number of Lanarkshire women living in East Kilbride and areas of South Lanarkshire bordering on the South East of Glasgow, who now deliver at Wishaw General Hospital.

Despite the amalgamation of Bellshill and Law maternity units into a single unit at Wishaw General Hospital, there has been very little net loss of hospital births to surrounding Health Boards. The most significant part of the Lanarkshire population who deliver within a different Health Board area comprise the population of Cumbernauld and Kilsyth, 80% of whom deliver in Glasgow and almost all the remainder deliver in Stirling or Falkirk.

Other aspects of the delivery of care, particularly in the community, have changed. In particular, there has been a significant increase in midwifery input to antenatal care. General practitioners have become less involved and although consultant-led antenatal clinics are still held at 13 locations in health centres throughout Lanarkshire and all women have an opportunity to see a consultant, much of the routine care in these clinics is undertaken by community midwives.

An effort to ensure that women have real choice has meant that home births have continued to rise (see chapter 2) and the opportunities for short stay in hospital have been enhanced due to the design of the maternity unit at Wishaw General Hospital. Length of stay of all women in hospital at the time of birth has declined over the past ten years (average 1.4 days).

In view of the significant changes which have taken place in the delivery of maternity care in Lanarkshire, the need for a new Maternity Services Strategy to cover at least the next five years has become clear.

This strategy presents the current demographic data for births in Lanarkshire and describes the current facilities, staffing and services, including supporting services, for clinical care. Finally, planning and developmental issues are discussed with a summary of proposals for the way forward.

## 2 DEMOGRAPHY

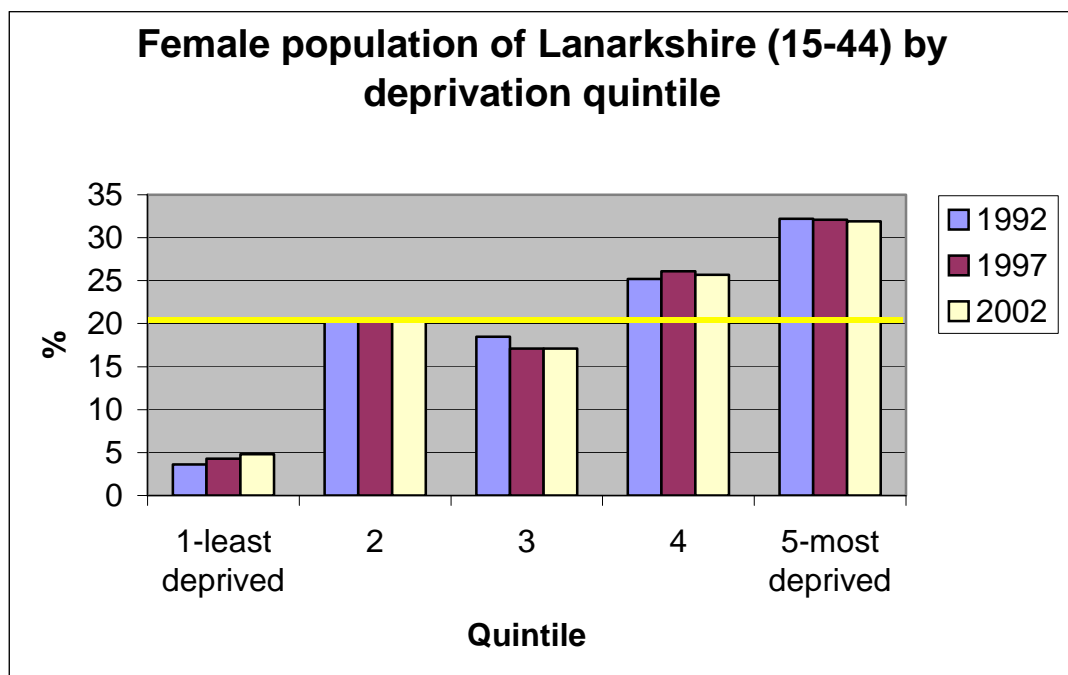
### 2.1 Women of childbearing age

The number of women in Lanarkshire aged 15 – 44 has fallen from 126,450 in 1981 to 124,685 in 1995 and to 117,704 in 2004. The number of women of childbearing age is projected to continue to fall to 111,115 in 2008, 102,968 in 2013 and 96,273 in 2018. This represents a fall of 5.5% in the last ten years and a projected fall of 12.5% over the next ten years.

### 2.2 Deprivation

The population can be divided into groups which record deprivation, based on census data. In Figure 1 the population of Scotland has been divided into deprivation quintiles. This means that 20% of Scotland's population is in each quintile grouping. As can be seen, there are fewer Lanarkshire women in the least deprived fifth and more women in the most deprived two fifths than one would expect.

Figure 1

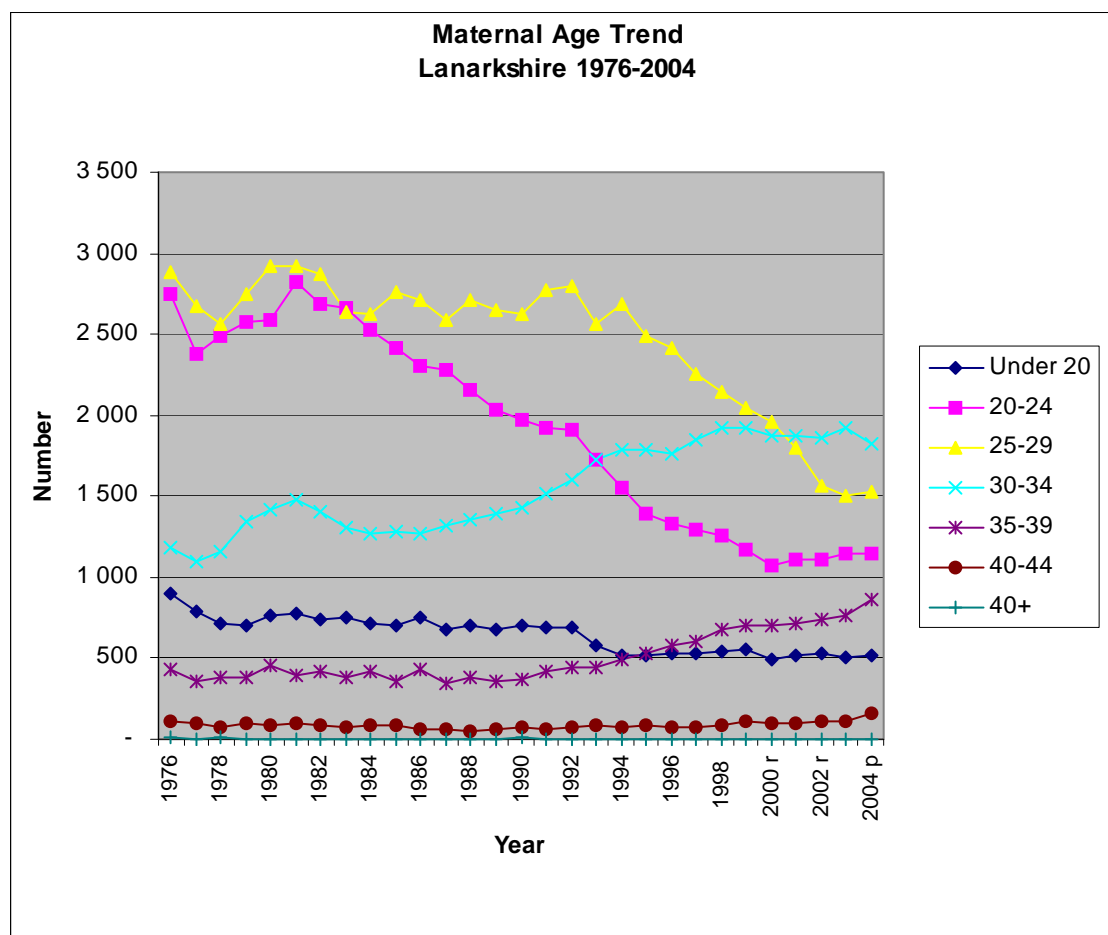


Source: NHS Board Variations in Maternity Care and Outcomes; Information Services; NHSScotland; Scottish Programme for Clinical Effectiveness in Reproductive Health; Edinburgh 2005

## 2.3 Maternal Age

The number of Lanarkshire women who are less than 30 at the time of giving birth has fallen significantly in the last two decades (**Figure 2**). At the same time, the number of older women has increased.

**Figure 2**



## 2.4 Ethnicity

At the time of the last census, Lanarkshire's ethnic minority population was less than 2%, mainly people originating from the Indian subcontinent. In the last 5 years there has been a significant influx of immigrants from Eastern Europe, the impact of which has been noticeable in maternity services through increased demand for interpreting services.

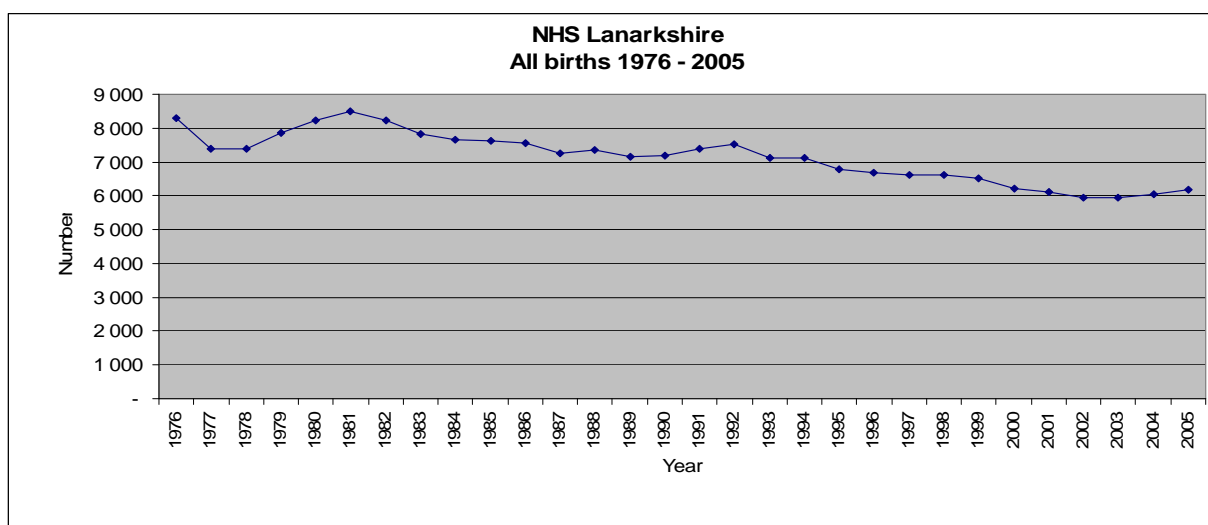
In early 2007, a group of Congolese asylum seekers were settled in Motherwell. It is likely that, in common with other areas of the United Kingdom, there will continue to be significant further immigration from EEC accession states, many of whom will be women of childbearing age.

Women from ethnic minorities have an increased risk of having a stillbirth, a neonatal death or dying from a pregnancy related complication.

## 2.5 Births

The total number of births to women resident in Lanarkshire has fallen over the last 25 years although there has been a rise in births in the last three years. (Figure 3) This is consistent with the trend in Scotland overall. It is not clear whether this signals an end to the long-term decline in births or whether it is a temporary change (as occurred in the early 1990s).

**Figure 3**



## 2.6 Outcome of pregnancy

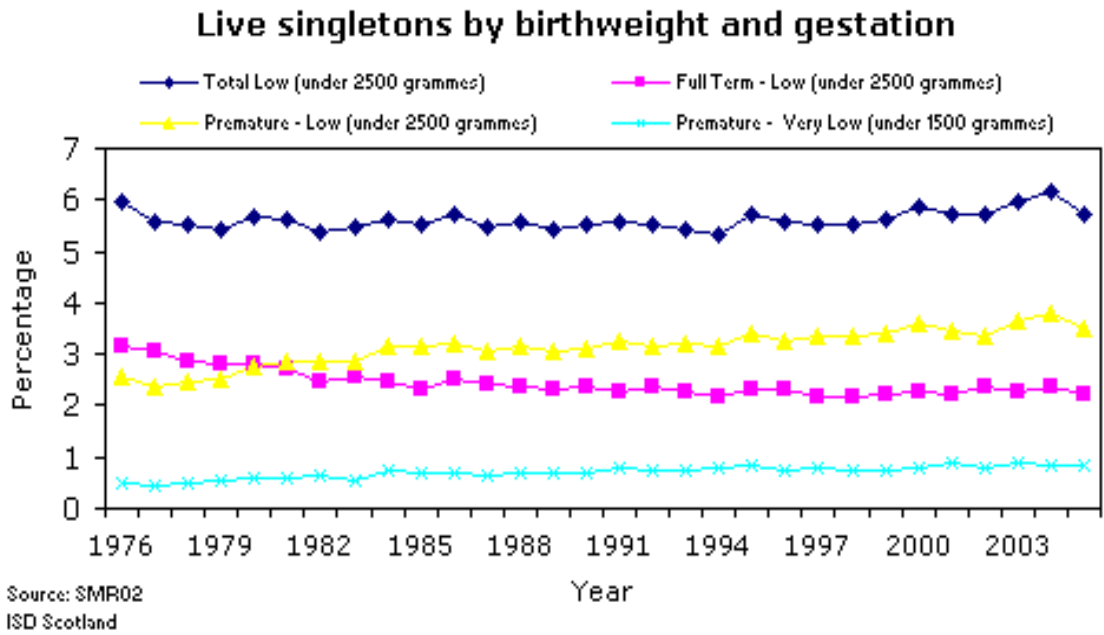
The perinatal mortality rate\* for Lanarkshire is slightly higher than the Scottish average. When deprivation and maternal age are taken into account, the rates are the same.

Figure 4 shows the trend in the proportion of infants in Scotland that are either small or premature or both. This illustrates that, although the total number of low birth weight babies has not changed significantly, the proportion of babies who are both premature and small or very small has increased. It is precisely these babies that require neonatal intensive care.

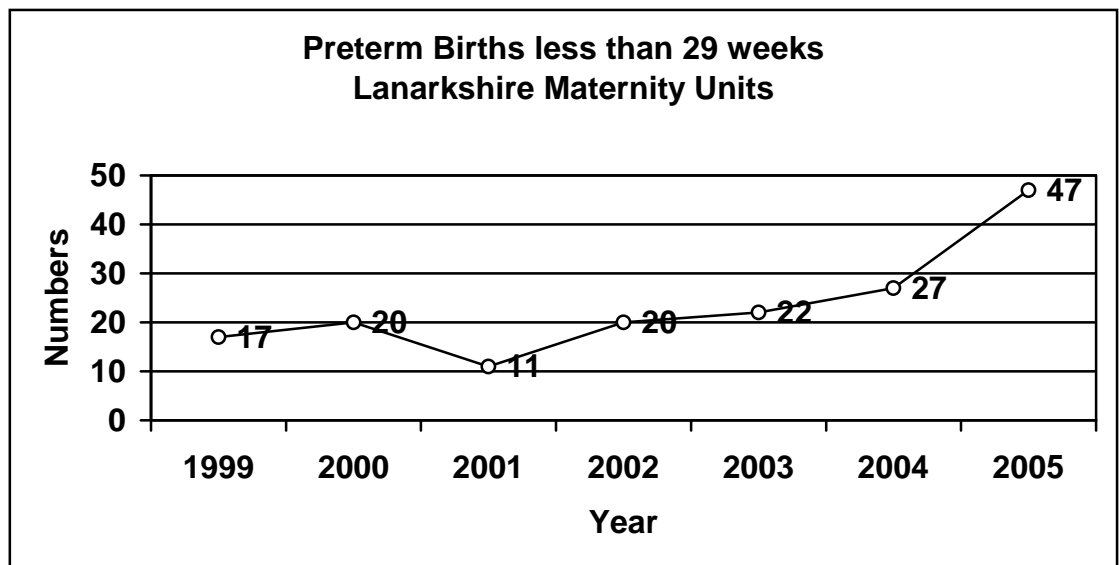
This is reflected in the rise in the number of very premature babies born in Lanarkshire (Figure 5)

\* Total number of stillbirths and neonatal deaths per 1,000 total births

**Figure 4**



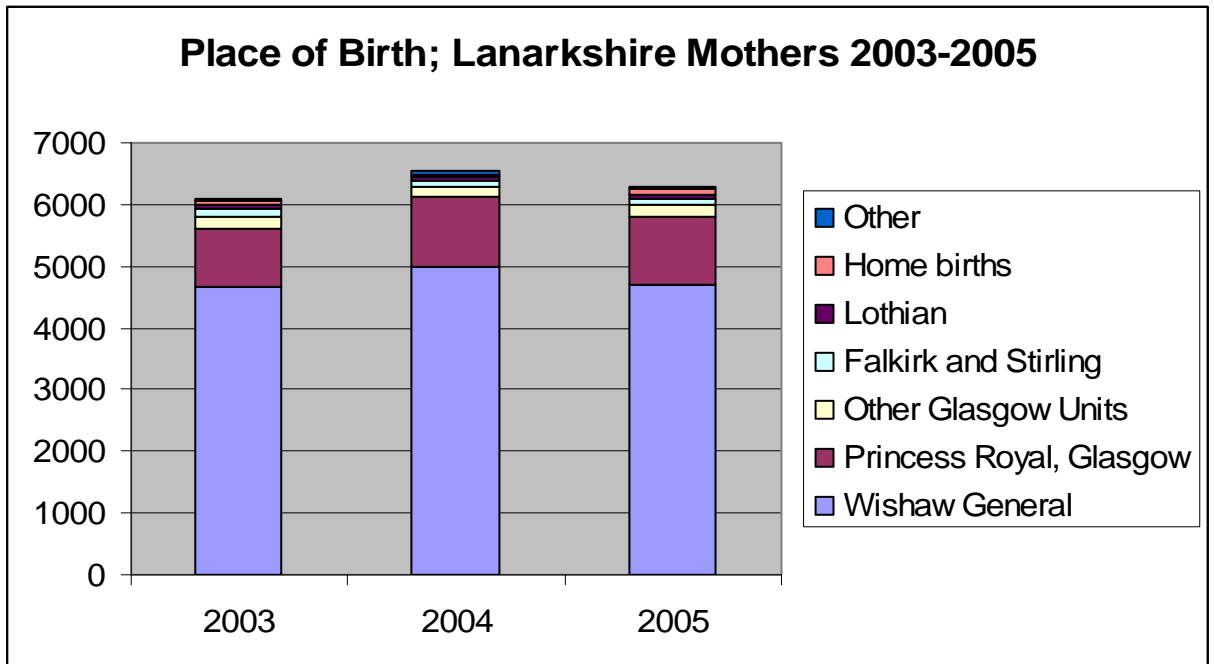
**Figure 5**



**2.6 Place of delivery**

While there have been slight variations in the total number of births as recorded in Figure 3, the proportions delivering in different hospitals or at home have not changed significantly. (Figure 6)

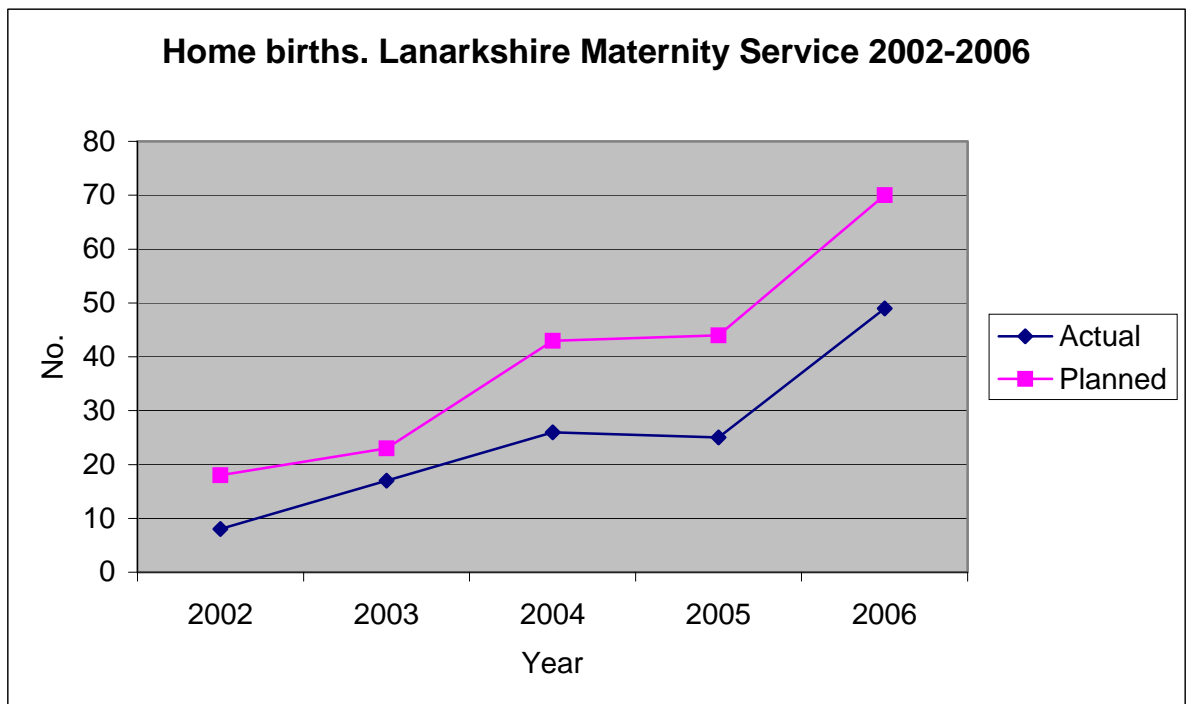
**Figure 6**



## 2.7 Choice

The number of planned and actual home births in Lanarkshire has risen sharply since 2000 (Figure 7). Nevertheless, this is still barely 1% of births.

**Figure 7**



## **2.7 Obstetric Interventions**

The proportion of live, singleton infants born by spontaneous vertex delivery has fallen from 71.7% in 1990-1992 to 62% in 2006. This decline is less than that for the whole of Scotland over the same period. About 1% of spontaneous vaginal deliveries in Lanarkshire occur in the birthing pool.

Rates of both elective and emergency Caesarean section have risen over time; from 5.9% (elective) and 10% (emergency) in 1990-1992 to 9% (elective) and 14% (emergency) in 2006. The current rates are rather higher than the Scottish average for elective and slightly lower for emergencies. They are well within the range of rates for individual Health Boards.

The rate of induction of labour has fallen from 24% in 1990-1992 to 22.3% in 2006. There are wide variations among NHS Boards; Lanarkshire rates are within the range of individual Health Boards.

## **2.9 Maternal mortality**

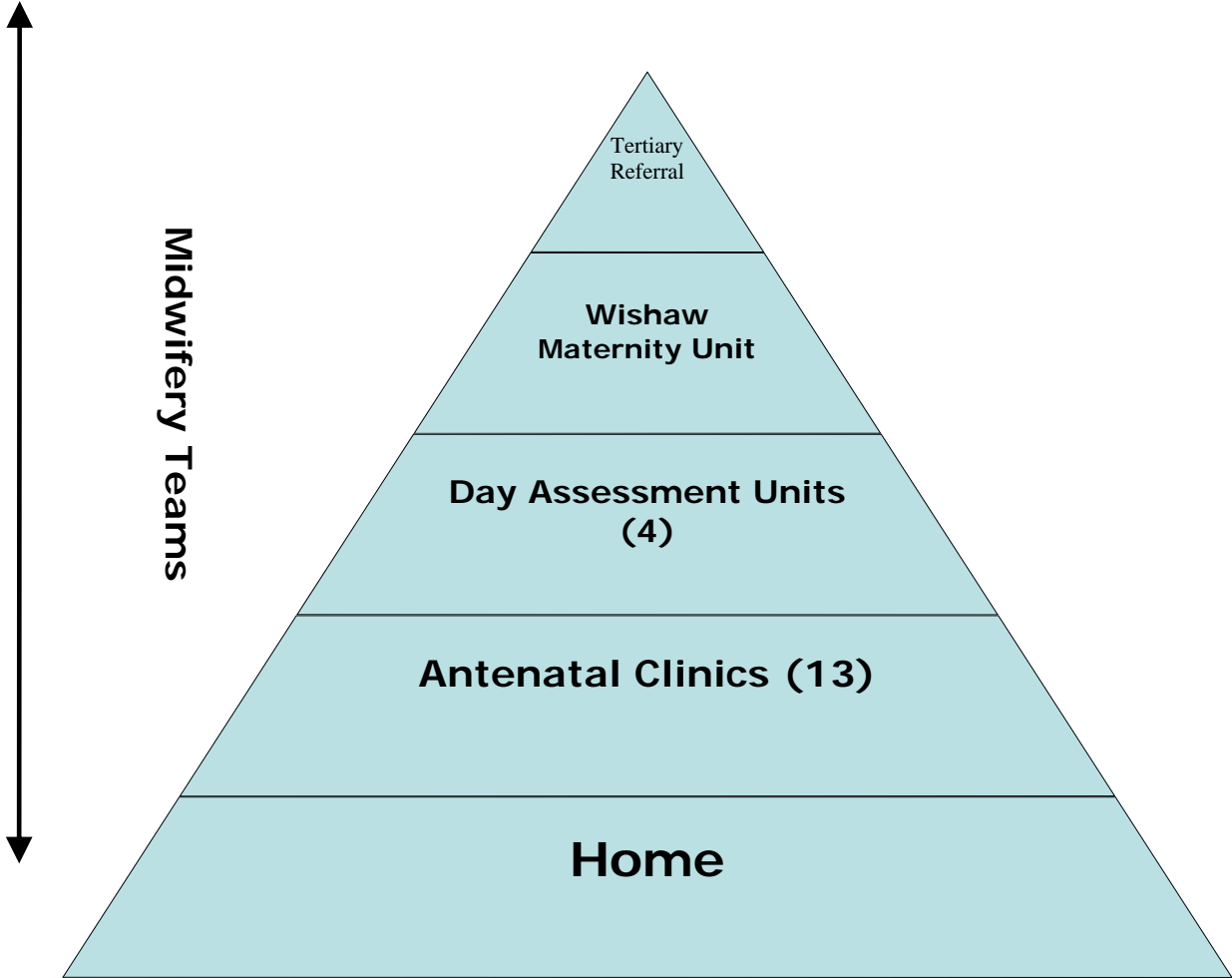
Maternal deaths are a relative rarity and are reported to a longstanding confidential enquiry into maternal mortality which reports every three years. The overall maternal mortality rate for the United Kingdom for the last triennium from deaths due to both Direct and Indirect causes is 13.1 maternal deaths per 100,000 maternities. Deaths from psychiatric causes are the leading cause of maternal mortality overall, followed by cardiac disease. There is about one maternal death in Lanarkshire each year on average.

**3 CURRENT FACILITIES**

The overall philosophy of the Maternity Service is to provide care as close to home as often as is possible, but to provide specialist care from a single maternity unit. The concept of midwifery teams provides continuity through all of the different levels of facility.

Since the opening of Wishaw General Hospital in June 2001, all inpatient maternity care and the great majority of deliveries have taken place within the maternity unit, which is an integral part of the new hospital. In addition, Maternity Day Assessment Centres are provided at Wishaw General Hospital, at Hairmyres Hospital, East Kilbride, and in Airdrie and Lanark Health Centres. Community midwives at midwife-led clinics within health centres and GP surgeries provide the majority of antenatal care. There are a total of 13 consultant-led antenatal clinics held within health centres.

**Figure 8: The Lanarkshire model of maternity care**



A brief description of the facilities within each of these three tiers of care follows.

### **3.1 Care in the Community**

Consultant led antenatal clinics are held at 13 locations throughout Lanarkshire in Health Centres (see Appendix 1). Ultrasound scanning facilities suitable for booking and dating scans are available at these Health Centres, substantially reducing the need for women to travel to hospital for an ultrasound scan. Midwives undertake most antenatal care and visits, with referral to an Obstetrician as and when required or requested.

There are no community maternity units in Lanarkshire, nor is there any demand to create one.

### **3.2 Maternity Day Assessment Units**

Of the four units within Lanarkshire, the largest is situated within the maternity unit of Wishaw General Hospital. All maternal and fetal surveillance facilities are available within this setting.

The units based at Hairmyres Hospital and Airdrie Health Centre provide a similar service although with fewer ultrasound scanning sessions.

The Day Assessment Unit in Lanark provides a maternal and fetal assessment service run by the community midwives, which reduces the incidence of women having to travel for day assessment services. Ultrasound scanning services are not currently provided within this facility.

### **3.3 Wishaw General Hospital**

The 79-bedded maternity unit is divided into four wards of approximately equal size. Labour, delivery, recovery and postnatal (LDRP) rooms are distributed throughout the unit, which minimises the transfer of women from one ward to another. Three wards are defined on a geographical basis i.e. women from the same area in Lanarkshire are admitted to the same ward where they will receive all of their care. The fourth ward is currently designated a high-risk ward and women identified as being within a high-risk category are admitted to this area.

In addition to the LDRP rooms there are a number of single bedrooms and four-bedded rooms to cater flexibly for the needs of pregnant and postnatal women. Two rooms are equipped for water births.

Immediately adjacent to the maternity unit are:

- Two dedicated obstetric theatres, one elective and one emergency. The obstetric theatres themselves are an integral part of the hospital general theatre suite
- A Maternity Day Assessment Area and Ultrasound Department
- A 29 cot Neonatal Unit providing intensive care, high dependency care, special care and rooming-in cots.
- An adult Critical Care Unit
- A comprehensive laboratory service

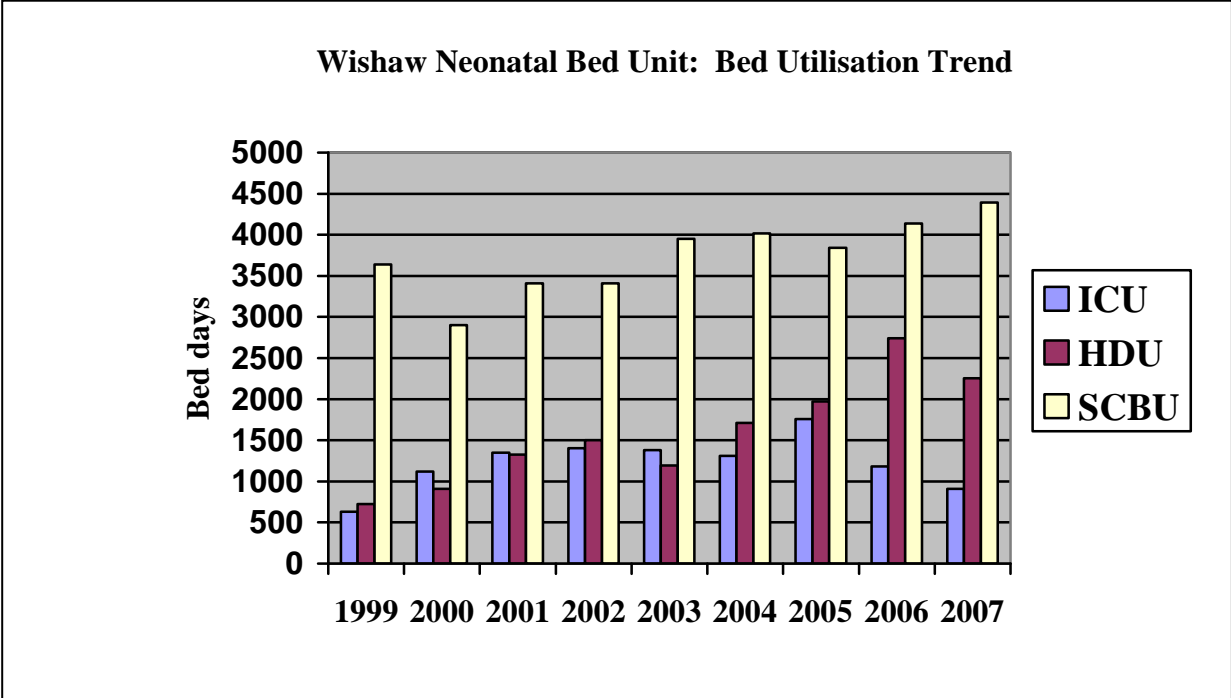
**3.4 Neonatal Unit**

Wishaw is a level III Neonatal unit (British Association of Perinatal Medicine definition). This means it is a Unit which provides the whole range of medical neonatal care but not necessarily all specialist services such as neonatal surgery.

The Neonatal unit is staffed for 8 intensive care cots, 10 high dependency cots and 11 special care cots.

As Figure 9 shows, there has been a substantial increase in the utilisation of Intensive Care and High Dependency Care cots which is attributed to a higher number of pre-term and low birth weight babies being cared for within the unit.

**Figure 9**



**4 STAFFING**

Staff numbers are summarised in Appendix 2.

**4.1 Midwifery**

Midwives are responsible for all low risk antenatal, intra-partum and postnatal care. Midwives all work between low, high risk wards, Neonatal unit, Day Assessment units and Community areas where they provide low and high risk care and take part regularly in the homebirth service. It is planned that the midwife will be the first point of contact in health care services.

A Practice Development midwife within the Maternity Unit ensures that midwifery training is ongoing and is evidence-based, achieved through the use of competency frameworks. In addition there is a Practice Education Facilitator who is a practicing midwife. The Practice Education Facilitator provides support to midwives who undertake a mentoring role with student midwives. They also ensure joint working between midwifery staff and higher education agencies. In-service education is paramount within joint training of medical and midwifery staff.

Training resource packs have been created for child protection, perinatal mental health, substance misuse and domestic abuse.

Wishaw General Hospital is a teaching hospital and provides practice placements for student midwives from the Hamilton Campus of the University of the West of Scotland. Midwives are mentors for these students and are responsible for their practice education during their placement in the clinical areas

## **4.2 Medical**

All Consultant Obstetricians have gynaecological as well as obstetric duties with the exception of one who has a major specialist interest in feto-maternal medicine. All middle grade and junior medical staff are in training grades.

Both the Neonatal and Maternity Unit are committed to training junior medical staff. Appropriate induction sessions are held and there is a continuing programme of formal and informal teaching. All trainees have a consultant as their designated educational supervisor. Career grade staff undergo annual appraisal.

Although each pregnant woman in Lanarkshire has an allocated consultant obstetrician who is ultimately responsible for clinical and medical management most regular care is delegated to midwives or to trainee medical staff. NHS Lanarkshire has an important role in training doctors, both in preparation for a career in obstetrics and gynaecology and for a career in general practice. Changes in the training of medical staff will take place in the near future and are described at Section 7.1.

## **5 THE PREGNANCY JOURNEY**

This section lays out the organisation of the main services available to women during pregnancy. It includes both the services that every pregnant woman can expect, tailored to her individual needs and choices, as well as those services available when special social or cultural needs are identified or complications arise.

### **5.1 Pre- Pregnancy**

The General Practitioner and the midwife give health promotion advice routinely in primary care. This advice covers diet, weight, smoking, alcohol and folic acid supplementation. Advice and the promotion of healthy lifestyles and a healthy pregnancy continues throughout maternity care.

For specific problems, there is a limited pre-pregnancy counselling service available at Wishaw Maternity Unit. Women who have had three or more miscarriages are offered this service. A monthly outreach Genetics clinic is also available for families who would benefit from genetic advice.

### **5.2 Early pregnancy**

Rapid access to scanning and advice is available to women who have bleeding or other complications in early pregnancy. An Early Pregnancy Assessment Service is available at the three main day care sites: 5 days per week at Airdrie and Wishaw and 6 days at Hairmyres. Advice is available at all times from the emergency gynaecology service, based at Wishaw General Hospital and directly accessible through NHS24. Support and advice from appropriately trained midwives/nurses is available at all three locations with medical advice and management as necessary. These services have substantially reduced the need for hospital admission for such women.

The service caters for just over 5000 referrals annually including some cross boundary referrals from Glasgow:

Airdrie: 1300, Hairmyres 2000, Wishaw 2000.

A pan-Lanarkshire multidisciplinary Early Pregnancy Assessment Group was established in 2003 and meets quarterly. This group has developed a range of guidelines, patient information leaflets and launched a successful outpatient service, using pharmacological rather than surgical methods, for the management of ectopic pregnancies.

The Group is committed to local and national collaborative audit and research.

### **5.3 Antenatal Booking**

Community midwives undertake the antenatal booking following self-referral from the woman or referral from the General Practitioner. The booking appointment takes place in general practice surgeries, antenatal clinics and frequently within the woman's home. An important feature of the booking visits and of all subsequent contacts is the identification of

any additional needs, particularly social and emotional needs which may not be apparent on initial enquiry. Identification of sensitive issues such as domestic abuse requires private time between the midwife and woman alone. Maternal and fetal surveillance is commenced with the midwife providing written information on the screening tests available. Options for delivery are discussed, the benefits of breastfeeding explained and a care plan is agreed with the woman and her midwife.

#### **5.4 Antenatal Care**

Antenatal care is woman-centred with the majority of women receiving midwife-led care in the community setting shared between GP surgery and consultant-led clinics. Ultrasound examination for the majority of women is performed within the consultant-led clinics in the community setting with the aim being that women will only require to attend the hospital for the birth itself.

#### **5.5 Preparation for Parenthood**

Parenthood classes are run throughout Lanarkshire. These include both general classes and classes targeted at specific groups such as teenage mothers. Fathers are actively encouraged to attend classes.

#### **5.6 Specialised Antenatal Care**

There are currently specialist antenatal clinics for diabetes, thrombophilia and multiple pregnancies.

A weekly antenatal clinic is held at Wishaw General Hospital staffed by a multidisciplinary team of nurse and midwife specialists, dietician, consultant physician and obstetrician. All women with diabetes as well as women with a range of other medical disorders are seen here.

Additionally a weekly multidisciplinary medical obstetric thrombophilia clinic is held at Wishaw staffed by specialist midwives and a consultant haematologist and obstetrician. Pre-pregnancy referrals are also accommodated at both clinics.

A consultant obstetrician also takes a special interest in multiple pregnancies and holds a clinic to see these mothers.

#### **5.7 Antenatal Screening**

Routine screening is undertaken during the antenatal period by the community midwife with referral to the appropriate specialist as required.

All pregnant women are offered an ultrasound scan at their first formal clinic appointment.

In addition to this service, fetal anomaly scans are offered to pregnant women with a medical or obstetric history which may result in a fetal abnormality. This facility is available at Wishaw and Hairmyres Hospitals and at Airdrie Health centre. Scanning is

provided by consultant obstetricians or appropriately trained radiographers with medical advice as necessary.

Lanarkshire participates in the West of Scotland Regional Genetic Service for neural tube and Down's syndrome screening. Serum screening is offered at 15-20 weeks gestation.

All women are routinely offered screening for a range of infectious diseases including HIV and Hepatitis B. Antenatal screening was introduced to Lanarkshire in June 2000 for Hepatitis B, and in June 2003 for HIV. The percentage of antenatal women who were tested during 2007 was 98.2% for Hepatitis B and 97.5% for HIV. Of these Lanarkshire women none were diagnosed as being HIV positive during pregnancy.

## **5.8 Prenatal Diagnosis**

This encompasses a range of services including counselling clinics staffed by specialist genetic liaison midwives with medical support as required, invasive ultrasound lists offering amniocentesis, and chorionic villus sampling.

Specialised fetal anomaly scanning is available at the three largest Day Care sites for a limited number of women with specific indications such as known risk factors or a family history. The majority of fetal anomalies diagnosed in the antenatal period are managed and delivered locally with referral to the regional fetal Medicine Unit as appropriate. A weekly neonatal and perinatal team meeting is held to discuss relevant cases and a monthly telemedicine link has been established with the Regional Multidisciplinary Perinatal Group at Yorkhill Hospital .

## **5.9 Complicated Pregnancy**

NHS Lanarkshire is able to deal with virtually all clinical complications, which may occur in pregnancy. Most are identified through a combination of the screening procedures described above, antenatal clinics and day care assessment with referral to one of the specialised antenatal clinics described above as necessary. Where appropriate, opinions from other medical specialists are sought.

The vast majority of complicated pregnancies are delivered at Wishaw General Hospital. The only reason for a planned delivery elsewhere would be because of prior knowledge of a neonatal problem which would require delivery at a unit with access to specialist paediatric services such as cardiology or neonatal surgery; or delivery of a woman with a particular medical or mental health problem e.g. a cardiac problem who would be best delivered at a site with appropriate cardiology attendance.

## **5.10 Birth**

The majority of births in Lanarkshire take place in hospital and a comprehensive maternity service is available at Wishaw General Hospital . A range of choices in the method of delivery is available to individual women to meet the expectations of their birth plan. Fathers are encouraged to attend the birth. Women in certain identified high risk categories may deliver within the high risk ward (Ward 24) but the majority of women deliver in an LDRP room in one of the three geographically defined wards. Intrapartum care is, on the whole, midwife-led with referral to an Obstetrician as and when required.

An epidural service with full anaesthetic support is available as is a comprehensive laboratory service including blood transfusion.

An increasing number of women in Lanarkshire opt for home birth under the care of the community midwifery team, ensuring antenatal, intrapartum and postnatal care is provided in the woman's own home.

## **5.11 Postnatal Care**

The design of Wishaw General Maternity Unit ensures that women in the postnatal period will receive inpatient care from the same team who provided antenatal and intrapartum care without the need to transfer between wards. On discharge, care will be provided by the community midwifery team who provided local antenatal care and this will be delivered in the woman's own home. This is normally until the 10th postnatal day or up to 28 days if required, prior to transfer from the Community Midwife to Public Health Nurse.

The child health programme for all children includes immunisation, screening, surveillance and health promotion. Some of this programme, such as parentcraft and infant feeding advice, begins well before birth. Other aspects, such as the neonatal clinical examination, neonatal hearing screening and blood spot screening, are delivered by the maternity service in the first few days of life. Identification of maternal mental health issues starts during pregnancy and is part of an integrated care pathway. The entire child health programme has been revised in line with the recommendations of the fourth edition of "Health For All Children".

## **5.12 Infant Feeding**

During pregnancy women are provided with information to enable them to make an informed decision about their infant feeding choice. Breastfeeding has major long and short-term health benefits for both mother and baby and NHS Lanarkshire promotes breastfeeding as the optimal feeding method for infants to ensure they have the best possible start in life<sup>1</sup>.

Fewer babies in Lanarkshire are breastfed compared with other health board areas in Scotland. The 1996 Lanarkshire Breastfeeding Strategy, and the more recent Strategy Review (2004), lays out a raft of measures to improve the situation<sup>2</sup> (2). The strategy highlights promotion and support for breastfeeding that reflects best practice standards and involves personnel at all levels in NHS Lanarkshire and partner agencies. The UNICEF UK/Baby Friendly Initiative (BFI) is currently being implemented to support this objective.

Maternity services in Lanarkshire have implemented the BFI Ten Steps to Successful Breastfeeding which provides recognised standards for providers to work towards best practice as well as a staged approach for BFI accreditation. Achieving UNICEF BFI accreditation involves a high degree of commitment and Maternity Services at Wishaw General Hospital have already achieved the UNICEF BFI Certificate of Commitment

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<sup>1</sup> Howie PW, Forsyth JS, Ogston SA, Clark A, du V Florey C (1990). Protective effects of breastfeeding against infection. *British Medical Journal* 300(6716):11-16

<sup>2</sup> *Taking Stock and Moving Forward A Review of the Lanarkshire Breastfeeding Strategy 2004*

(April 2005), Stage 1 accreditation November 2007 and are working towards full accreditation by January 2009.

A network of support for breastfeeding is available in all geographical areas and includes:

- Mother to Mother Breastfeeding Support Groups
- Breastfeeding Workshops
- Peer Support Projects
- Incentive schemes in some deprived areas
- Written and Verbal information

For women who choose not to breastfeed, full support is given by midwives and public health nurses and a range of pre-prepared formula milk is available for use in the Maternity Unit.

### **5.13 Neonatal Special and Intensive Care**

All medical neonatal care is provided within Lanarkshire at Wishaw General Hospital. All viable newborns greater than 22 weeks are cared for within this facility. There exist within the department modalities for advanced respiratory support, parenteral nutrition, inhaled Nitric Oxide therapy and telemedicine links for cardiac and surgical cases.

The maternity unit transfers patients to and from other units because of neonatal and in-utero issues. However, the most frequent reason for transfer is due to capacity issues within the Neonatal Unit, rather than for any specific medical reason.

There is an acknowledged shortage of neonatal intensive care cots in Scotland. A centralised bureau finds available cots when cots are full in the most local unit. This has meant that babies are sometimes transferred to Wishaw from other neonatal units and sometimes babies born in Wishaw are transferred to other neonatal units in Scotland.

Neonatal transfers are conducted by a dedicated neonatal transport service for the West of Scotland.

A nationwide study is currently being undertaken looking at all antenatal, intrapartum and post-delivery transfers and outcomes.

## **6 SUPPORT FOR CLINICAL CARE**

The pregnancy journey is supported by a range of other activities described in the following section. These provide support and quality assurance for clinical care.

### **6.1 Scottish Women's Hand Held Maternity Records (SWHMR)**

In April 2007 NHS Lanarkshire implemented the use of SWHMR notes as directed by the Scottish Executive. The SWHMR notes are taken to all clinic and hospital appointments. These notes are hand held and access to them is available at all times by all health professionals caring for the pregnant women. There is an opportunity for the women to add her comments as necessary.

### **6.2 Information Technology**

Information systems for the maternity service are rudimentary. There is a maternity audit database which allows online data entry. However data for submission to the national SMR02 database has to be completed by hand. There is no link to the hospital patient management information system.

### **6.3 Clinical Governance**

The maternity service is accountable for the standard of clinical care to the Acute Division's Clinical Board and thereafter to the Health & Clinical Governance Committee of NHS Lanarkshire Board. There are several mechanisms through which this accountability is ensured.

#### **6.3.1 Risk Management**

The Maternity Service has a well-established Clinical Risk Management Strategy with notification and screening procedures in place and a mechanism for implementing recommendations. A Risk Manager supported by a Directorate Risk Management Team leads this process.

#### **6.3.2 Clinical Effectiveness**

A multidisciplinary group regularly reviews guidelines and protocols for use within the maternity unit and is developing auditable standards. The group meets monthly and liaises closely with the Directorate Risk Management Group, which reports ultimately to the Board's Risk Management Committee. Quarterly hospital seminars established in 2003 provide a successful forum for the launch and development of new guidelines. In addition, the maternity unit participates in multi-centre and unit based research projects.

### **6.3.3. Midwifery Supervision**

The role of a Supervisor of Midwives is to protect the public by empowering midwives and midwifery students to practise safely and effectively. Supervisors are accountable to the Local Supervising Authority (LSA) for all supervisory activities. The LSA is Lanarkshire Health Board. The Board delegates authority to the LSA Midwifery Officer, who is appointed for the West of Scotland Region.

The role of the Supervisor is distinct from that of a manager and all supervisors have equal status. Their function is to set and monitor standards of practice alongside the Local Supervising Authority Midwifery Officer (LSAMO). To fulfil this role, Supervisors need to be familiar with the Statutory rules, local policies and protocols where each midwife works.

They are responsible for:

- Providing professional leadership
- Give advice, guidance and support to women accessing maternity services
- Contributing to activities e.g. risk management and clinical audit
- Yearly meetings with their supervisees offering support, evaluating their practice and identifying areas for development
- Providing guidance on registration and opportunities to keep updated in regards to Statutory requirements
- Receiving and processing intention to practice forms yearly
- Reporting lack of competence or misconduct to the LSAMO
- Ensuring appropriate care is available to all women and families
- Participating in the preparation of new supervisors of midwives and identifying when peer supervisors of midwives are not undertaking the role to a satisfactory standard by taking appropriate action.

### **6.4 Joint Service with Local Council Social Work (Including Child Protection)**

Maternity Services work with North Lanarkshire and South Lanarkshire Councils to support women where there is concern about their capacity to care appropriately for a child or there are other risks to the family. This concern may arise from any of a series of factors which lead either health or social work professionals to think that a child, yet unborn, may be in need of protection. The most important specific areas covered by joint working are drug misuse and domestic violence. More general joint working supports younger mothers and mothers affected by poverty and deprivation.

### **6.5 Maternity Services Liaison Committee**

The EGAMS report of 2003 highlighted that Health Boards should ensure they have greater public involvement and that they strengthen the role of Maternity Services Liaison Committees (MSLCs). The purpose of an MSLC is to bring together professionals within maternity services, service users and members of the public. NHS Lanarkshire state that the purpose of their MSLC is “to inform the development of NHS Lanarkshire’s Maternity

Services Strategy through active engagement and consultation with service users, their families and other key stakeholders, both outside and within the NHS”.

The MSLC was re-established with an enhanced remit in 2004. Although committed to greater public involvement, it has thus far failed to recruit any recent maternity service users who are representative of the community.

The MSLC aims to meet once every 3 months and in future be chaired by a Lay member. Membership currently comprises of a range of health professionals involved in the care of both women and babies, service managers, GPs, University of the West of Scotland representative, breastfeeding co-ordinator, as well as representatives from Health Promotion, the Ethnic Minority Action Group, various support groups such as the NCT and a lay representative.

This should be an exciting and challenging period for the MSLC as it shares in the development of the new NHSL Maternity Strategy for 2008 – 2013, as well as local and national developments and priorities.

## 7 PLANNING ISSUES

### 7.1 DRIVERS FOR CHANGE

This section examines the drivers for change emanating from planning guidance and strategy at national, regional and local level. We also consider here the pressures from specific guidance and inevitable changes in population dynamics and health technology.

#### 7.1.1 *National Issues*

Delivering for Health<sup>3</sup>, the Scottish Executive response to the Kerr Report<sup>4</sup> confirms the importance of the Framework for Maternity Services<sup>5</sup> and of the Expert Group on Acute Maternity Services (EGAMS)<sup>6</sup>:

“The framework and strategic direction for maternal health in NHS Scotland is detailed in “A Framework for Maternity Services”, published in 2001, and the report of the Expert Group on Acute Maternity Services which followed in 2003. We will continue to implement the conclusions and recommendations of these reports to improve services for Scotland’s families, mothers and their babies. The National Framework for Service Change reiterates the central principles of both documents, and we accept the recommendations it makes.”

The recommendations of the Kerr report in respect to maternity services are reproduced at Appendix 6.

#### 7.1.2 *Regional Issues*

Regional planning of Maternity Services in the West of Scotland has been established. Whereas Lanarkshire had made changes which anticipated the recommendations of EGAMS, reconfiguration is likely in neighbouring Health Board areas.

Wishaw is currently the second largest maternity unit in the West of Scotland, second only to the Princess Royal Maternity Unit and the third largest in Scotland, Edinburgh Royal Infirmary being bigger. The midwifery and obstetric activity is reflected in the very busy neonatal unit. Altogether, this means that the Lanarkshire Maternity Service is critical to the provision of Maternity Services in Scotland.

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<sup>3</sup> Delivering for Health; Scottish Executive; Edinburgh. 2005

<http://www.scotland.gov.uk/Resource/Doc/76169/0018996.pdf>

<sup>4</sup> Building a health service fit for the future: a national framework for service change in the NHS in Scotland (“The Kerr Report”). Scottish Executive Health Department  
Edinburgh: Scottish Executive, 2005

<http://www.scotland.gov.uk/Resource/Doc/924/0012112.pdf>

<sup>5</sup> A framework for maternity services in Scotland. Scottish Executive Health Department; Edinburgh: Scottish Executive, 2001

<http://www.scotland.gov.uk/library3/health/ffms-00.asp>

<sup>6</sup> Implementing a framework for maternity services in Scotland: overview report of the expert group on acute maternity services. Scottish Executive Health Department  
Edinburgh: Scottish Executive, 2003

<http://www.scotland.gov.uk/library5/health/ifms-00.asp>

### **7.1.3 Local Strategy**

The need to make a strategic plan for maternity services in Lanarkshire comes partly from this national and regional pressure, but also has its origins in other pressures described above. There are major workforce pressures in the NHS, particularly those which arise as a consequence of medical staff contracts, the European Working Time Directive, Modernising Medical Careers and Agenda for Change. The solution to some of these pressures present opportunities for innovative midwifery-led and nurse-led services.

### **7.1.4 Changing maternal demography**

There are specific pressures due to demographic change in maternity services. The conception rate in women over the age of 30 is rising, while falling among younger women. Older mothers are significantly more likely to have a complicated pregnancy<sup>7, 8</sup> and to give birth to small, premature babies with a higher risk of multiple births and congenital abnormality.

### **7.1.5 Maternity Care Plan**

In response to a statement in the Maternity Services Framework, NHS QIS led the development of a new maternity case record - the Scottish Woman Hand Held Maternity Record (SWHMR)<sup>9</sup>. It was introduced throughout Scotland in 2007. The record is a great advantage to women transferring between maternity services. All clinical information is available to all health professionals during pregnancy and the postnatal period in both hospital and community settings. At the end of the maternity care episode all information is retained in the hospital medical records department.

### **7.1.6 Antenatal Screening**

Antenatal care continues to develop. Evidence of the benefits from screening programmes is gradually accruing and current best practice requires significant expansion in capacity for detailed ultrasound scans in the mid trimester as well as implementation of combined ultrasound and biochemical screening in the first trimester (CUBS screening), as recommended in the NHS QIS standards for pregnancy and newborn screening, which cover all aspects of antenatal screening.<sup>10</sup>

### **7.1.7 Promotion of Choice**

A further source of pressure is the continued and appropriate expectation of choice in how pregnancy and particularly childbirth take place. The number of home births in Lanarkshire is rising and will probably continue to do so. The rate of home births is still far behind the

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<sup>7</sup> Bewley S. Davies M. Braude P. *Which career first?* [Editorial] *BMJ*. 331:588-9, 2005

<sup>8</sup> Grant, John M. *Social class and elective caesareans in the NHS: Dr Foster is cheap and offensive* *BMJ*. 329(7460):291 (2004)

<sup>9</sup> Bedford H. Chalmers J. *A New Vision for Maternity Records in Scotland: The Scottish Woman-Held Maternity Record (SWHMR) Project and the electronic Scottish Woman-Held Maternity Record (eSWHMR) Project* *The Journal of the Institute of Health Record Information & Management (UK)*; 44: 2 (2003)

<sup>10</sup> Clinical Standards – Pregnancy and Newborn Screening. NHS Quality Improvement Scotland 2005  
[http://www.nhshealthquality.org/nhsqis/files/Pregnancy%20%20Newborn%20Screening%20\(Oct%202005\).pdf](http://www.nhshealthquality.org/nhsqis/files/Pregnancy%20%20Newborn%20Screening%20(Oct%202005).pdf)

rate expected if full choice were expressed. Increased home births will put additional pressure on midwifery resources.

Yet a further issue for the future is the difficulty of effectively engaging women of childbearing age in the development of maternity services. Although a Maternity Services Liaison Committee has been successfully established, it still lacks sufficient representation from service users. The service will continue to engage in national debate relating to public involvement in Maternity Services and best practice for Maternity Service Liaison Committees.

### **7.1.8 Public Health**

The public health challenges of Lanarkshire are particularly important in relation to maternity services. The determinants of health status in adulthood begin in pregnancy and early life. Maternal smoking levels remain resistant to change; breastfeeding rates are low and the number of mothers who abuse drugs or alcohol rises inexorably. Domestic Abuse is a common problem in Scotland; one in five women are affected. Pregnancy is a time when domestic abuse is known to increase.

Mothers living in the most deprived areas (deprivation quintiles are calculated using the Index of Multiple Deprivation score) seem to be twice as likely to have a stillbirth as women living in the least deprived areas. Furthermore, the babies of such mothers are 2.2 times more likely to die in their first month of life.<sup>11</sup> The babies of mothers from ethnic minorities and of young mothers, are also more likely to die in the first month than the babies of white women and women over twenty.

The public health role of midwives is becoming increasingly important as a consequence of these factors. Some areas of Scotland have recognised this by appointing a consultant midwife or developed specialist midwifery posts to lead on these issues. Specialist midwifery roles in substance misuse, smoking, breast feeding and domestic violence have also been developed.

### **7.1.9 Neonatal Care**

Many of these factors have either a direct or indirect effect on neonatal care. Expectations of neonatal care increase, the technological capacity of care is developing all the time and there are significant pressures on limited capacity, both locally and nationally. A Ministerial Action Group report for the provision of Neonatal Services across Scotland is expected imminently.

### **7.1.10 Medical Training**

Profound changes will occur in medical training over the next few years as the “Modernising Medical Careers” programme is implemented. This officially started in August 2005 with first foundation year trainees, which have now replaced the pre-registration house officer grade. Second foundation year trainees in obstetrics, paediatrics and gynaecology commenced in the specialty in August 2006. They spend four months in the specialty, rather than six months as previously. Trainees need to demonstrate a number

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<sup>11</sup> Perinatal Mortality 2005, Confidential Enquiry into Maternal and Child Health, London 2007 [www.cemach.org.uk](http://www.cemach.org.uk)

of competencies during this period. The organisation of a programme which allows achievement of these competencies is important. It is envisaged that, at the end of the second foundation year, those wishing to continue in obstetrics and gynaecology or in paediatrics (including neonatology) will be identified and there will be a seamless “run through training” to recognition as a specialist. To date there has been no significant impact on trainee doctors within obstetric or neonatal specialties, however it may have a significant impact on the provision of professional care and the delegation of responsibilities.

## **7.2 LOCAL CURRENT CHALLENGES**

NHS Quality Improvement Scotland published clinical standards for maternity care in 2005. NHS Lanarkshire was visited and assessed in February 2006. Issues identified within the final report are described below:

### **7.2.1 *Pre-pregnancy Services***

Limited pre-pregnancy services are available within existing specialised antenatal clinics. These services are currently overstretched. There are no formal arrangements for pre-pregnancy advice within the maternity service although a monthly genetic clinic is held by staff from the genetic centre at Yorkhill Hospital and a pre-pregnancy service for women with recurrent miscarriages does exist in the form of a clinic for such women.

### **7.2.2 *Early Pregnancy Services***

Early pregnancy assessment services are located at 3 sites i.e. Wishaw General Hospital, Hairmyres Hospital and Airdrie Health Centre. Women with a poor obstetric history or bleeding in early pregnancy or certain other related problems can be appointed directly to these services which have ultrasound facilities and appropriate counselling and advice. Midwifery and nursing staff provide this service with the backup of medical staff as necessary.

Currently there is insufficient capacity to meet demand which requires women to attend ultrasound sessions at regular clinics at which appropriate counselling and advice are less readily available.

A full range of EPAS services are available on all 3 sites Monday to Friday with a Saturday service only being available at Hairmyres.

Where necessary, inpatient beds for those with early pregnancy problems are all located at Wishaw General Hospital mainly in the Maternity Unit, but on occasions in the gynaecology ward.

Three options are normally available in the management of miscarriage i.e. conservative, medical or surgical management. The existing facilities make the options for medical management limited and there is often difficulty arranging theatre time and accommodation for those opting for surgical management.

### **7.2.3 *Midwifery Resources and Unit Design.***

Since opening in 2001 the maternity unit at Wishaw General Hospital has not been able to function entirely as was originally envisaged with uniformity of access to different levels of care throughout all four wards. A high-risk ward (Ward 24) is used for the care and delivery of a large number of women and the equalisation of care throughout the wards has been hampered by the epidural service being limited to two wards (Wards 23& 24).

A considerable amount of midwifery time is taken up with relatively minor reasons for admission and with the high number of early pregnancy problems which pass through the maternity unit. This limits the ability of the midwives to adequately perform their core function of care of women in labour and of mothers and babies postnatally.

A Birth Rate Plus survey of midwifery practice at Wishaw General Hospital in 2005 confirmed a shortfall of midwifery staff for the current work within the unit in view of the way the staff have to be deployed. Birthrate Plus methodology and a professional judgement tool have recently been applied as part of the national Nursing and Midwifery Workforce and Workload planning project.

### **7.2.4 *Neonatal Care***

Although there has been significant investment to increase the cot base within the neonatal unit at Wishaw General Hospital there are still occasions when it is full beyond capacity. This limits ability to deal with ill neonates necessitating the transfer of babies to other units' either in utero or postnatally. Although this to some extent reflects a national problem in Scotland, the lack of a transitional care area for neonates within the Maternity Unit means that babies may have to stay in the Neonatal Unit longer than would be the case were a transitional area available. This exacerbates the problem locally.

### **7.2.5 *Support Services for the Neonatal Unit***

In addition to the capacity of intensive care and deficiencies in transitional care, there are a range of developments in the service which would be desirable to bring the unit up to the optimum standard. These include a range of clinical supports (dietetics, phlebotomy, psychology, bereavement counselling and dedicated social work); training of advanced neonatal nurse practitioners and the delivery of outpatient follow up clinics in a range of locations.

In response to the Scottish Executive directive ending the employment of non-contract agency nurses, a training programme has been put into place to train staff with the appropriate skills for the Neonatal Unit.

### **7.2.6 *Maternity Services Liaison Committee***

The main strength of the MSLC is that it brings together professionals, service users and members of the public. However, it also faces some barriers to success including the lack of awareness of the existence and functions of the MSLC amongst women and service users in general in Lanarkshire, which would be helped by recruiting new lay members.

Despite some difficulties, the MSLC has great potential. It will be able to discuss national and local developments and respond to consultations; consider the implementation of

standards from bodies such as NHS QIS and the Scottish Government as well as NHS Lanarkshire priorities; to discuss issues of importance to women and service users in Lanarkshire; to have effective two-way communication with the public ensuring that the views of those who may previously have been marginalized, such as those from ethnic minorities and those who are socially disadvantaged, are included. Good practice can also be highlighted and shared. A lack of funding and training for lay representatives presents a threat to the success of the MSLC as does the lack of crèche facilities, which may mean that some ideal volunteers would be unable to attend meetings. This would be unfortunate as the aim is to recruit women who have delivered within the last five years.

All members of the Committee however require to be fully aware of all the developments, issues and documents that drive change within maternity provision and this could be achieved simply by providing keynote presentations on major relevant issues. None of the difficulties are insurmountable if NHS Lanarkshire wishes the MSLC to progress.

### **7.2.7 IT/PMS**

The current maternity information systems are extremely limited. A decision on a maternity module, linked to the Wishaw Hospital Patient Management System, automatically generating the information download for SMR02 is urgently needed. Systems are also required to generate data for the Scottish Birth Record and to link information on neonatal care to the Child Health Information Systems which are started as soon as a baby has a CHI number allocated. At present NHS Lanarkshire is not able to provide comprehensive data as requested by various bodies such as that required for the annual LSA report to the Nursing & Midwifery Council.

### **7.2.8 Infant Feeding**

The NHS Lanarkshire Breastfeeding Strategy was first published in 1996, reviewed in 2004 and is currently undergoing review again. The strategic aims of this strategy are:

- To increase the proportion of women breastfeeding at birth, for at least six weeks and for at least 4 months.
- To achieve the target of 35% of women breastfeeding at 6 weeks

Maternity Services will be integral in the delivery of these aims by continuing to work and support interventions identified by the Breastfeeding strategy group including:

- Working toward full UNICEF Baby Friendly accreditation
- Health Education
- Peer Support Initiatives
- Media Campaigns

## **8 FINANCIAL FRAMEWORK**

The total budget for maternity care for Lanarkshire women is not easily defined.

The main part of the maternity services staff (midwives, sonographers, administrative and clerical staff) is an identified part of the women's services budget. This maternity budget is £19.1M in the current year.

- Share of clinical resource costs (e.g. physiotherapy, laboratories)
- Share of hospital running costs

Other elements of the total cost of maternity services are:

- Medical staffing costs (consultants and non-consultant career grade staff)
- Core costs of medical staff in training (met by NHS Education for Scotland)
- Additional duty costs of medical staff in training
- Budget for neonatal paediatric staff in all grades is held by Children's services (part of primary care division)
- Cost of maternity services provided by other NHS Boards (mainly NHS GGC and NHS Forth Valley).

## **9 THE WAY FORWARD**

This section draws on the descriptive material of the current facilities and provision of care for Maternity Services in Lanarkshire as well as the drivers for change in a national and regional context, as well as local challenges described in Section 7. From this information a Strategy for Maternity Services can be developed. It is assumed that there will be no radical change in the location of most care that is provided nor in the type of service. The proposals contained in NHS Lanarkshire's strategic development envisage no change in the inpatient base for Maternity Services established at Wishaw General Hospital. There are also no plans to alter the present structure of four day-assessment centres with a wide range of community, antenatal and postnatal facilities. It is therefore presumed that these facilities will remain in place and that, if anything, the development of local Health Centres will make better community facilities available.

### **9.1 NATIONAL, REGIONAL AND DEMOGRAPHIC PRESSURES**

There are three significant risks which would lead to increasing pressure on local maternity services in the next five years:

- The impact of regional changes leading to an increase in the demand on local services
- Continued increase in the number of older mothers with attendant higher risks of complicated pregnancy and birth
- An increased demand for home births.

Although no major changes are envisaged in the facilities for provision of care in Lanarkshire, this may not be true of surrounding health board areas. Changes planned in the Greater Glasgow and Forth Valley Health Board areas are unlikely to have a major impact on the numbers of Lanarkshire domiciled women using Lanarkshire's Maternity Services; it is likely that any net losses may be offset by net gains. Nonetheless any strategic thinking must take cognisance of developments occurring in adjacent Health Boards. An assumption can, however, be made that the total number of deliveries at Wishaw General Hospital may be relatively unchanged over the next five years. However, trends suggest that there may be an increasing proportion of older mothers who may have more complications and may increase pressure on the Maternity and more particularly the Neonatal Service.

The number of home births seems likely to continue to increase and midwifery staffing levels must take account of this. An alternative approach would be to follow the policy in place in some other Boards of capping the total number of homebirths.

Major changes are likely to take place in the next few years in the structure of medical staffing, particularly in the trainee grades. This is addressed further in paragraph 9.4 and may have important implications for the provision of both maternity and neonatal care by medical staff.

#### **9.1.1 *Scottish Woman Held Maternity Record***

A national decision has been made to adopt the hand held record for use by all women at the antenatal and early postnatal stage. This has important implications for the provision of care including the management of clinics, the medical records department, communication between health professionals and between women and health professionals, and in the pattern of care including the identification of the lead health

professional for each pregnant woman. NHS Lanarkshire commenced use of the SWHMR early in 2007 and have been involved in a National Group set up to review the issues from the first version and the development of the second version which should be available early 2008. It will be necessary to form a multi disciplinary group, comprising midwifery, medical and lay personnel and possibly members of the allied health professions to ensure that the advantages of the Record are fully realised. SWHMR gives a structure to the identification of family, cultural and social needs and a framework for planning support. The facilitation of improved recognition of risk factors and a seamless flow of information to and from those who need it will be an important part of this piece of work.

During a recent inspection visit, NHS QIS commented that there was a higher level of consultant input to care than in other areas of Scotland. The implementation of SWHMR will provide an opportunity to refine and rationalise medical input to antenatal care and to enhance the provision of midwifery care based on a dynamic risk assessment process.

There will be ongoing revenue costs associated with the purchase of the record.

### **9.1.2 Antenatal Screening**

The Scottish Government Health Department is committed to providing a uniform level of antenatal screening for chromosomal and neural tube defects for all women in Scotland. This includes the provision of facilities for carrying out combined ultrasound and biochemical screening in the first trimester (CUBS screening), and also the provision of a routine ultrasound scan at approximately 20 weeks gestation screening for structural fetal anomalies including neural tube defects<sup>12</sup>.

This will require the provision of additional scanning equipment and staff as well as additional training for existing staff, and will be an important priority for the strategic development of Maternity Services in Lanarkshire within the next five years. Planning for this development is being carried forward by the Pregnancy and Newborn Screening Implementation Group.

Further work is required to ensure effective reporting and monitoring of the antenatal blood born virus screening programme.

### **9.1.3 Social Issues of Relevance to Maternity Services**

Women of childbearing age should be an important priority group for all general health promotion in Lanarkshire. This should include smoking cessation, diet, exercise and alcohol and substance misuse control.

An alcohol and substance misuse development officer for maternity services has been recently appointed, however ongoing funding for the post is uncertain beyond 2008. Funding has also been secured for the development of two midwifery posts for substance misuse.

The early recognition of social problems during antenatal care is critical to ensuring that needs are assessed and support planned in advance of birth. Maternal drug misuse, alcohol misuse and domestic abuse are frequently related. The babies of the increasing number of pregnant women who are misusing drugs have an important impact on the neonatal unit. Both pregnant women and their children in families affected by factors such as these, have

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<sup>14</sup>Business case for implementation of anomaly scanning approved. Implementation plan developed

long-term risks to their health and well-being. Families in these groups often use health services poorly and the observation afforded by maternity care may be a unique opportunity to pick up significant risk factors.

The implementation of the “Hall 4” Child Health programme means that the pattern of public health nurse contact is set as a consequence of assessing a family’s need. To ensure the right level of contact and support, assessment of a family needs to begin as early as possible and preferably during antenatal care.

Although teenage pregnancy rates are lower in Lanarkshire than elsewhere in Scotland, there is no room for complacency. There is a separate sexual health strategy which deals with this.

Infant feeding is strongly determined by socio-economic factors. Only 12% of the babies of teenage mothers from the most deprived areas are breast fed, compared to 72% of older mothers in the least deprived areas. The continuing elements of the breastfeeding strategy which need to be pursued are:

- Training for all staff groups, both UNICEF and in house education
- Continued work towards UNICEF Baby Friendly Accreditation
- Health Education
- Peer Support
- Media Campaigns

The creation of an Infant Feeding Development Midwife would help address issues such as delivery of in house education and support, and development of staff on a day-to-day basis within hospital and community environments.

Undertaking a survey of women in relation to attitude and beliefs regarding breastfeeding could inform further work to increase the initiation and sustained breastfeeding rates.

## **9.2 LOCAL ORGANISATION OF SERVICES**

The earlier parts of this strategy have identified specific deficiencies in some key areas in the provision of care. These are summarised again below with details of strategic solutions, which should be addressed in an early part of this five-year plan.

### **9.2.1 *Early Pregnancy Services***

Whether the management of early pregnancy problems, particularly bleeding in early pregnancy, should fall within gynaecological or maternity services has been a matter of debate for some years. It is well recognised that the ideal solution is the creation of a separate area in the hospital setting for the management of these problems, and also to create a streamlined service with good access from the community for those experiencing early pregnancy problems.

Although an ultrasound scanning service is available at three locations within Lanarkshire, the hours of opening of these services are limited. Ways should be explored to improve access to this service and to expand it to seven days a week. This seven day service should be provided at Wishaw General Hospital, where there is ready access to medical and midwifery support at all times.

The current provision of inpatient care for early pregnancy problems is unsatisfactory, as it is not separate from other pregnancy cases and has irregular and uncertain access to the operating theatre for surgical management. The creation of a dedicated early pregnancy assessment area in one of the maternity wards with provision of a comprehensive service for the medical management of miscarriage and ready and flexible access to operating theatres would substantially improve the quality of care for women.

As described below, the provision of such an area in one of the existing maternity wards (probably Ward 21) is an obvious solution to part of the problem. Access to theatre would be improved by the provision of an additional elective theatre list within the maternity theatre, and a business case for this is being processed by the Anaesthetic Directorate. Utilising elective gynaecology theatre lists on a daily basis for surgical management of miscarriage will also be explored.

### **9.2.2 Neonatal Care**

Section 7.2.4 of this strategy document has described the problems of the neonatal unit at Wishaw General Hospital, which regularly has occupancy rates in excess of 100%. It has been apparent for some time that the creation of a transitional care area for neonates within the maternity unit would alleviate some of the pressure on the neonatal unit.

This will become even more pressing if the number of neonatal intensive care units in the West of Scotland reduces. The creation of such an area would be possible with the changed utilisation of Ward 21 as described below. Midwifery Resources and Unit Design

Sections 7.2.3 of this document summarises the historical development of the Maternity Unit at Wishaw General Hospital. It has not been possible to run the unit as originally envisaged with equal access to all services throughout the unit, and changes in design and the use of one of the maternity wards (probably Ward 21), as described below, could address this.

## **9.3 REVISED WORKING ARRANGEMENTS OF WISHAW GENERAL HOSPITAL MATERNITY UNIT**

The three problems described above in sections 9.2 would be amenable to solution by converting one of the maternity wards (probably Ward 21) into a ward which provided three different services i.e. early pregnancy care, emergency triage and assessment, and neonatal transitional care. There is an opportunity to improve the quality of care for all three and to guarantee equality of care in labour throughout the unit, especially in the provision of an epidural service, by freeing up the other three maternity wards to concentrate on labour, delivery and postnatal care. Removing from the other maternity wards women with early pregnancy problems, those requiring medical or midwifery assessment but not necessarily admission, and women staying in merely because their baby is in the special care unit, should mean that there are sufficient beds in the three remaining maternity units to cater for all other needs. A study is underway to confirm this. This should result in more efficient use of midwifery resources with the provision of an equally high quality of service throughout the unit.

Minimal structural change would be required to Ward 21 to make part of it a 4-6 bedded early pregnancy unit. Another 4-6 bedded area could be utilised for the assessment of 'emergency' maternities and approximately 10 beds for a neonatal transitional care. All three parts of Ward 21 would require appropriate midwifery staff. Careful analysis of the problem might allow

better use of existing midwives by removing these particular categories of patients from the other three maternity wards.

As well as providing a fixed base for the supervision, management and monitoring of those with early pregnancy problems, the early pregnancy centre would also provide a unit for the medical management of miscarriage, an option denied to many women in Lanarkshire at present. It would also provide a base from where women could be transferred to either the gynaecological or maternity theatres for surgical management of miscarriages. Being admitted to, and recovering in, a dedicated area will substantially improve the quality of care for these women.

A further use of the early pregnancy unit might be as the centre for the development of further pre pregnancy services which, as described in section 7.2.1 above, are presently limited.

Examples of babies who might be retained in the transitional care unit include babies with transient neonatal problems such as hypoglycaemia, hypothermia, jaundice or feeding problems, babies with congenital abnormalities but not requiring special care, babies on intravenous antibiotics and babies with neonatal abstinence syndrome.

Clear guidelines would be drawn up for babies that would be suitable for admission to this unit.

Clear criteria and guidelines would be needed to indicate which women would be assessed in the Ward 21 triage area, as opposed to being admitted directly to one of the maternity wards. In addition, the relationship between the triage area and the existing day assessment unit will require clear guidelines.

The redesign of Ward 21 as described would require 24 hours a day, 7 days a week opening for all three categories of use, but it is likely that utilisation would be substantially lower at night time, and redistribution of staffing might be appropriate at that time.

## **9.4 HEALTH PROFESSIONAL WORKFORCE**

Significant changes in the structure of staffing provision are envisaged in the next five years. This section describes the workforce pressures and presents projected workforce requirements to deliver the recommendations within this strategy.

### **9.4.1 *Medical Obstetric Workforce***

As described in the section 7.1.6 above, profound changes are occurring in medical training. The most junior medical staff will be unable to provide anything other than a very rudimentary service, and there may be severe depletion of the middle grade tier of medical staff who provide most of the day-to-day specialised care to women in the maternity unit. It seems unlikely that there will be a large expansion in the number of consultants to provide this care and at the time of writing, it is unclear how this service will be provided, but it is likely that initially there will be retention of the existing numbers of middle grade staff, but as they shrink in future years their role will have to be filled by more fully trained doctors who have not yet attained a consultant post. This important issue is one of national importance and Lanarkshire will not have a local solution, but may need to use its medical workforce flexibly to continue to provide a high level of care. The increased role of the midwife, the need for more specialised scanning and pressures on medical staff from the demands of gynaecology, may mean that the role of the consultant in the antenatal clinic may be appropriate for review.

At the present time it is not envisaged that there will be a division of medical staff into those providing gynaecological or obstetric care.

Midwifery workforce planning projections have taken account of challenges in the obstetric workforce.

#### **9.4.2 *Midwifery Workforce***

An extensive workforce planning exercise was undertaken as part of re-organisation of maternity services and subsequent migration to Wishaw General Hospital in 2001. Publication of a Framework for Maternity Services in 2001 and EGAMS report in 2003 acknowledged workforce pressures in maternity services in Scotland and recognised the need to have a more flexible approach to service provision and workforce planning, to ensure sustainable maternity services are maintained. In April 2004 the SEHD published recommendations from the Nursing and Midwifery Workload and Workforce Planning Project. This document identified that within Scotland most midwifery workforce plans were based on historical budgets and professional judgment and recommended that a more structured approach should be adopted, stating that the most commonly used tool in maternity services is Birthrate Plus. Since publication of this document NHS Lanarkshire have undertaken a review of the midwifery workforce requirements using Birthrate Plus in August 2005, GRASP workforce planning tool in November 2006 and a normative model based on clinical judgment in November 2006. Analysis of these workload measurements suggested that an increase in midwifery workforce was required. The new role of Maternity Care Assistant (MCA) has been identified as one way of developing and modernising the maternity workforce in order to be responsive to current and future needs. NES developed competencies for this role and have piloted a course in Robert Gordon University which has evaluated well. Two candidates were successful in completing this course and a further two have been seconded this year. This role will enable a further skill mix to be introduced to the midwifery workforce.

As midwives become the lead clinician for normal pregnancy, labour and the postnatal period the need for expert clinicians and clinical leaders has increased. As a result the Scottish Government have partially funded a midwife consultant post in each Health Board area to lead on the Keeping Childbirth Natural and Dynamic (KCND) project. Within NHS Lanarkshire funding has been secured for a full time midwife consultant who will lead the model of care described within the maternity strategy.

In 2007 the Scottish Government commissioned a maternity sub group of the Nursing and Midwifery Workload and Workforce Planning Project (NMWWPP) to identify workload measurement tools that would be appropriate for use in maternity services. This group agreed Scottish Parameters for Birthrate Plus, identified a professional judgment tool appropriate for maternity services, and a quality assurance tool based on Clinical Quality Indicators is currently being developed. Every maternity unit in Scotland will undertake Birthrate Plus and the professional judgment tool. These workforce measurement tools take account of national policy, best practice statements, new roles and medical workforce pressures described above. They can therefore be used in a predictive capacity for the midwifery workforce requirements to deliver this strategy.

### **Current Midwifery Workforce**

Band	Funded Establishment	In post
8B	1	1
8A	1	1
7	73.37	73.37
6	122.08	122.08
5	2	2
4	5.10	5.10
2	37.9	37.9

Predicted Midwifery Workforce based on NMWWPP recommendations would suggest that if a skill mix review to reduce the number of band 7 midwives and increase the number of band 6 midwives is undertaken then the current funding will enable the recommended establishment to be achieved.

#### **9.4.3 Neonatal Workforce**

Implementation of Modernising Medical Careers, European Working Time Directives and other professional influences have had a significant impact on workforce planning within Neonatal Services. It has therefore been necessary to undertake a detailed review of the medical and nursing workforce and to implement new roles to ensure that a sustainable, safe and effective service can be maintained in the future.

In addition the cot base within the Neonatal Unit was increased from 22 to 29 cots in 2007. This required additional nursing and medical staffing as described in the financial appendix below. Additional nurse staffing has been recruited, however additional consultant staffing has yet to be funded.

Taking these factors into account the proposed medical, ANNP and nursing workforce is described below:

#### **Medical Workforce**

##### **First Receiving Rota**

Currently 3 FY2 and 3ST1s populate the 1<sup>st</sup> receiving rota supported by 1.6wte ANNPs. It is anticipated that the number of junior trainees will reduce and that training will be less service delivery focussed. It is proposed that by 2011 the first receiving will be populated by ANNPs as described in the financial schedule below.

##### **Middle Grade Rota**

Currently 2 staff grades and 4 trainees of differing levels of experience populate the middle grade rota. It is anticipated that the number of middle grade trainees will reduce to 2 by 2010. It is proposed that once ANNPs gain the necessary skills and experience that they will advance to support the middle grade rota, however it may be necessary to employ 2 additional non career grade doctors to populate this rota in the short term until the ANNPs acquire the necessary skills and experience. The cost of this may be offset against the loss of trainee doctors.

##### **Consultant Staffing**

Currently Consultant medical staffing is 4.2wte. Taking account of the impact of increasing the cot base, additional supervision required for trainee and qualified ANNPs,

and for junior doctors it is proposed that this should increase to 5.2wte as described in the finance schedule below.

### **ANNP Workforce**

As described above in order to maintain a safe, effective and sustainable neonatal service for NHS Lanarkshire the role of the Advanced Neonatal Nurse Practitioner (ANNP) has been developed. This role enhances a multidisciplinary approach to care with a merging of traditional medical and nursing roles.

The role of the ANNP is a senior clinical role incorporating both medical and nursing management of neonates and their families. Although there are many interpretations of the role of the ANNP nationally, it has been agreed that the role within Lanarkshire will support sustainability of the 1<sup>st</sup> receiving rota and that once experience has been gained and skills developed that there will be potential for some ANNPs to support the middle grade rota. The business case for expansion of the neonatal cot base included a schedule for training and recruitment of 8.4wte ANNPs in the next 5 years. This schedule is included in Appendix 3. To date 1.8wte qualified ANNPs are in post, 0.6wte has temporarily deferred training and 2wte are in the first year of training which is slightly behind schedule due to the 0.6wte training deferment. As described above it will be essential to maintain recruitment of ANNPs and trainee ANNPs to ensure the sustainability of neonatal services in the future.

### **Neonatal Nursing Workforce**

Extensive workforce modelling was undertaken in 2007 in preparation for the expansion of the cot base within the neonatal unit. Workforce was agreed based on a normative model based on clinical judgement, GRASP workforce planning tool and BAPM guidelines.

A neonatal sub group of the Nursing and Midwifery Workload and Workforce Planning Project was also commissioned in 2007 to identify workload measurement tools that would be appropriate for use in neonatal services. This group agreed that BAPM recommendations, a professional judgment tool and a quality assurance tool devised by the group would be used for workload measurement. NHS Lanarkshire has completed this process and is expecting feedback in summer 2008. This will give quantitative and qualitative data on which work undertaken in 2007 can be benchmarked.

The Nursing and Midwifery Council have made clear their intention to restrict the areas in which direct entry midwives can work. There is a risk associated with this move because there are currently fifteen direct entry midwives who are currently working in the neonatal unit and who might not be permitted to do so in future. It will therefore be necessary to focus nursing recruitment to Children's Nurses and to develop innovative rotational posts with paediatric services which will ensure a sustainable nursing workforce in the future.

### **Current Nursing / Midwifery Workforce**

Band	Funded Establishment	In post
ANNP	2.4	1.6
7	5.97	5.97
6	55.15	56.36
5	1	1
4	3.44	3.44
2	5.45	5.45
<b>Total</b>	<b>73.41</b>	<b>73.82</b>

## Predicted Midwifery Workforce based on implementation of ANNP Role

Band	Funded Establishment
ANNP	8.4
7	8.97
6	48.15
5	5
4	3.44
2	5.45
<b>Total</b>	<b>79.41</b>

Additional costs for implementation are detailed in the approved business plan for expansion of the neonatal cot base.

### 9.4.4 *Allied Health Professionals*

Physiotherapists, ultrasonographers and dieticians provide an important input to Maternity Services. Since the concentration of inpatient gynaecological services at Wishaw General Hospital in 2006, additional strain has been placed on the physiotherapists based in the hospital, and an expansion of the physiotherapy department may be necessary to maintain the necessary standards of physiotherapy care for women in the maternity unit.

As described in Section 9.1.3 above, there will be a much greater demand for ultrasound scanning in pregnancy within the next few years. Some of this additional scanning will be carried out by medical and possibly by specifically trained midwifery staff, however there will be an increased demand for ultrasonographers and NHS Lanarkshire must plan to provide sufficient ultrasonographers to provide the service for CUBS screening and fetal anomaly scanning at 20 weeks gestation. It is anticipated that an additional 3.6wte sonographers will be required to implement these recommendations. In recognition that recruitment to these posts will be difficult, it may be necessary to invest in training posts initially to ensure a sustainable service can be provided in the future.

## 9.5 FINANCIAL FRAMEWORK

The financial framework for implementation of this strategy is detailed below:

RECOMMENDATION	COST	FUNDING STREAM	PROGRESS TO DATE	STATUS
1. Development of a dedicated Early Pregnancy Service	Minor works and removal of bathroom in ward 21	Non-recurring funding provided for reconfiguration of ward 21 and gynaecology move to ward 13 Nov 2007	Implemented 10 <sup>th</sup> March 2008	<b>GREEN</b>
2. Implementation of midwife led care for low risk women	Cost neutral		Implemented 21 <sup>st</sup> April 2008	<b>GREEN</b>
3. Examine the implications for NHS Lanarkshire of CEL on antenatal screening published in July 2008	Unknown	CEL identifies £164k recurring (for 3 years) and £455k non-recurring funding allocation for NHS Lanarkshire	Group established to examine implications of the CEL on equipment, staffing and training requirements	<b>RED</b>
4. Introduction of anomaly scanning	Capital Cost £220k Revenue Cost £100k	Business case approved by Acute DMT	Equipment purchased Sonographer training commenced May 08 Agency sonographer appointed for 4 months- Additional £12k funding agreed	<b>AMBER</b>
5. Development of a dedicated maternity triage and assessment area	Minor works and removal of bathroom in ward 21	Non-recurring funding provided for reconfiguration of ward 21 and gynaecology move to ward 13 Nov 2007	Implemented 10 <sup>th</sup> March 2008	<b>GREEN</b>

6. Development of infant feeding development midwife post	Band 7 midwife post £42k	Review of skill mix in midwifery posts	Currently advertised	<b>AMBER</b>
7. Development of specialist midwifery posts to enhance the public health role of the midwife	2 Band 7 midwife posts £84k	Funding proposal to ADAT for recurring funding	Outcome awaited	<b>AMBER</b>
8. Implementation of expanded neonatal cot base to 29 cots	See appendix 2	Business case endorsed by risk management steering group. Case approved by Acute DMT	<ul style="list-style-type: none"> <li>• Nursing recruitment complete</li> <li>• ANNP recruitment partially complete</li> <li>• Equipment purchased</li> <li>• Consultant post not yet approved</li> <li>• Plans for building work approved work not yet undertaken</li> </ul>	<b>GREEN</b> <b>AMBER</b> <b>GREEN</b> <b>RED</b> <b>AMBER</b>
9. Procurement of a robust maternity information system	Unknown	Business case to be developed	Work commenced on the development of e-SWHMR linked to Scottish Birth Record by ISD	<b>RED</b>
10. Implementation of recommendations from Nursing and Midwifery Workforce and Workload Planning Project	Cost Neutral	Existing funded establishment	Skill mix review to be undertaken by Sep 2008	<b>AMBER</b>
11. Neonatal Workforce Development	1.0wte Consultant Neonatologist	Within neonatal business case approved by Acute DMT	Neonatal update paper to be presented to Acute DMT	<b>RED</b>

**GREEN** – Fully implemented

**AMBER** – Funding stream identified not yet implemented

**RED** – Funding stream not yet identified

## **9.6 PATIENT FOCUS AND PUBLIC INVOLVEMENT**

The Maternity Services Liaison Committee needs to be re-energised. Key elements of this are:

- The recruitment of additional lay members, supported by training and funds to meet expenses.
- Raising public awareness of the role of the MLSC
- Develop representation from ethnic minority and more deprived communities

## 10 RECOMMENDATIONS

The Actions and Risks identified in this section reflect the strategy described in sections 7 and 9.

The Actions will need to be agreed and prioritised as a first step before putting forward prioritised proposals to the Maternal and Child Health Programme Board and eventually to the Modernisation Board.

Risks have been identified separately. The progress of each of these will need to be separately monitored and outline contingency plans developed.

Ref	Action	Responsibility	Timescale	Progress
9.3	Carry out an assessment of the need for pre-pregnancy services			
9.3	Creation of a dedicated early pregnancy assessment area in Ward 21 with provision of a comprehensive service for the medical management of miscarriage and ready and flexible access to operating theatres			
9.1.2	Full funding of introduction of detailed fetal anomaly scans at twenty weeks (Business case approved, implementation plan being actioned)			
9.1.2	Full funding of introduction of CUBS screening			
9.1.2	Ensure effective reporting and monitoring of the antenatal blood born virus screening programme.			
9.1.3	Evaluate and, if appropriate, secure sustainable funding for the maternity services alcohol and substance misuse development officer			
9.1.3	Ensure maternity services are fully incorporated in the smoking cessation strategy			
7.2.7	Commission maternity services information system linked to hospital PAS			
9.1.1	Meet ongoing revenue costs associated with the purchase of SWHMR .			
9.2.1	Expand access to ultrasound to seven days a week			
9.4.2	Develop terms of reference for a review of professional roles in maternity care,			

<b>Ref</b>	<b>Action</b>	<b>Responsibility</b>	<b>Timescale</b>	<b>Progress</b>
	considering the introduction of SWHMR, risk assessment and guidelines.			
9.4.4	Enhance training for all staff around public health, social and cultural issues			
9.1	Agreed policy on restriction of access to home births if demand puts other parts of service at risk			
9.3	Create an emergency triage area in Ward 21			
7.2.4	Complete and implement findings of review of neonatal unit demand and capacity			
7.2.4	Review management of neonatal unit, specifically the management arrangements for medical staff			
9.2.2	Create neonatal transitional care area within Ward 21			
	Assess need for a range of clinical supports (dietetics, phlebotomy, psychology, bereavement counselling and dedicated social work), training, and services (e.g. outpatients) in neonatal care			
7.2.8	Implement Lanarkshire Breastfeeding strategy			
9.4.1	The competencies of Maternity Care Assistants have recently been described by NHS Education Scotland. Local development work is required to identify their role in local midwifery services, including an evaluated pilot.			
9.4.3	Review need for physiotherapy			
9.5	The recruitment to the MSLC of additional lay members, supported by training and funds to meet expenses.			
9.5	Raising public awareness of the role of the MLSC			
9.5	Develop representation on the MSLC from ethnic minority and more deprived communities			

## RISKS

Ref.	Risk	Monitoring arrangements	Progress with contingency plans
9.1	A continuation of a trend in increased births, driven increasingly by the development of new housing in Lanarkshire.		
9.1	The impact of regional changes leading to an increase in the demand on local services.		
9.1	Continued increase in the number of older mothers with attendant higher risks of complicated pregnancy and birth.		
9.1	Increased number of home births		
9.4.2	Impact of Modernising Medical Careers: <ul style="list-style-type: none"> <li>• Lack of specialist capacity of foundation doctors</li> <li>• Reduced experience of specialist trainees</li> <li>• Shortfall in capacity of consultant staff and lack of available appointees in the medium term</li> </ul>		
9.4.1	Regulation restricting the work settings of direct entry midwives		
9.4.1	Longer term impact of end of Off-contract employment		

## GLOSSARY

<b>Accredited</b>	Certified as being of a prescribed quality.
<b>Acute Maternity Services</b>	Services providing care during labour and delivery.
<b>Amniocentesis</b>	A test carried out during or after 15 weeks of pregnancy for fetal abnormality. The test involves the removal of a small amount of fluid from the amniotic sac by aspiration through the abdominal wall, for diagnostic purposes.
<b>Antenatal Care</b>	Care of women during pregnancy by professionals in order to detect, predict, prevent and manage problems with women or their unborn babies. Care also includes education, advice and support.
<b>Audit</b>	The measuring and evaluation of care against agreed standards with a view to improving practice and care delivery.
<b>Caesarean Section</b>	An operation where the baby is delivered through an incision through the abdominal and uterine walls.
<b>Cardiotocograph</b>	A test of fetal well-being and uterine contractions. A combination of electro-cardiography and tocography. The fetal heart rate is obtained by a microphone placed on the woman's abdomen or by an electrode attached to the fetal scalp during labour. At the same time contractions of the uterus are measured by a tocograph placed on the woman's abdomen. Both are recorded on a monitoring device.
<b>Community Maternity Unit</b>	A maternity unit, midwife managed, occasionally with GP involvement, which may be a stand-alone unit or adjacent to a non-obstetric hospital or adjacent to a maternity unit.
<b>Competency</b>	Required level of skill and proficiency.
<b>Congenital Abnormalities</b>	An anomaly present at birth.
<b>Continuity of Care</b>	This term is used to describe a situation where all the professionals involved in delivery of care share common ways of working and a common philosophy. The aim being to reduce conflicting advice experienced by women, and the same philosophy of care is experienced by the woman throughout the period of her care.
<b>Continuity of Carer</b>	The same professional providing care throughout a woman's contact with the maternity services. It can also be used to describe the same caregiver throughout a specific episode of care, such as during labour and

	childbirth.
<b>Demography</b>	The study of statistics on births, deaths and diseases.
<b>European Community Working Time Directive</b>	The Working Time Directive provides for minimum daily and weekly rest periods, annual paid holidays, a limit on the working week of 48 hours and restrictions on night work. It excludes from its scope transport, work at sea and doctors in training.
<b>Fetal</b>	Of the fetus.
<b>Fetus</b>	The unborn baby, usually referring to development from the seventh week of pregnancy until birth.
<b>Guidelines</b>	Systematically developed statements which assist in decision-making about appropriate health care for specific clinical conditions.
<b>Home Birth</b>	This is usually a planned event where the woman decides to give birth at home, with care provided by the midwife. It is normal for 2 midwives to be present for the birth. Occasionally the GP is involved in the care and present at the birth.
<b>Integrated Care Pathways</b>	A coherent approach to providing health promotion, detection and treatment for a specific illness.
<b>Integrated Service</b>	A multi-disciplinary, multi-professional approach to service provision.
<b>Intrapartum</b>	The period during labour and delivery.
<b>In-utero</b>	In the uterus/womb, unborn.
<b>Lead Professional</b>	The professional who will give a substantial part of the care personally and who is responsible for ensuring that the woman has access to care from other professionals as appropriate.
<b>Local Health Care Co-operatives (LHCC)</b>	These co-operatives are GP-led and were set up to address the health needs of local communities through a multi-disciplinary and multi-agency forum.
<b>Maternity Services Liaison Committee</b>	A committee set up within a NHS Board area which provides a forum for all the professions involved in the provision of maternity care, with representatives of the women who use the services to discuss issues relevant to the provision and development of maternity services in the area.
<b>Maternity Unit</b>	A building or group of buildings in which maternity care is provided. It can be located within, or adjacent to, a general hospital, or away from the general hospital.
<b>Multi-disciplinary</b>	An approach combining the knowledge, skills and expertise of a range of organisations and professionals.

<b>Multi-professional</b>	Care delivered by a team of health professionals.
<b>Named Midwife</b>	A named, qualified midwife who will be responsible for woman's midwifery care.
<b>Neonatal Period</b>	The first 28 days of a baby's life.
<b>Obstetric</b>	The branch of medicine and surgery that deals with pregnancy and childbirth
<b>Perinatal</b>	The period including birth and the following seven days
<b>Postnatal</b>	After the birth
<b>Postnatal Period</b>	A period not less than 10 days or more than 28 days after the end of labour, during which time the attendance on the mother and baby by a midwife is mandatory.
<b>Premature Baby</b>	Born before the due date (less than 37 weeks gestation).
<b>Primary Health Care</b>	Primary Health Care is health care at the first point of contact with the Health Service, addressing physical, social and psychological problems, but also providing continuity of care. The traditional Primary Health Care Team of General Practitioners working with nursing, administrative and other support colleagues has largely been expanded to include colleagues from other agencies and disciplines relevant to the delivery of care appropriate to the person's needs.
<b>Principles</b>	A code of direction.
<b>Professional</b>	In this report, Professional usually refers to those who have been specially trained in health care such as the midwife, the GP, the obstetrician, the anaesthetist, the paediatrician/neonatologist and the public health nurse.
<b>Protocol</b>	An adaptation of a clinical guideline or a written statement to meet local conditions and constraints, which has legal connotations.
<b>Resuscitation</b>	The revival of someone who is in cardiac or respiratory failure or shock.
<b>Screening</b>	Mass examination of the population to detect specific illnesses.
<b>Shared Care</b>	An agreed arrangement between a GP and an obstetrician, a GP and a midwife or an obstetrician and a midwife over care for a pregnant woman.
<b>Strategy</b>	A plan or a policy to achieve something.
<b>Supervisor of Midwives</b>	A statutory function whereby a midwife who has completed the appropriate training is appointed to the role of Supervisor of Midwives. The role encompasses the provision of support and guidance for midwives, protection of the public, contribution to the regulation of

the practice of midwives and promotion of high quality care. Each midwife has a named Supervisor of Midwives.

**SWHMR**

Scottish Woman Held Maternity Record

**Telemedicine**

Refers to any application of information and communications technology which removes or mitigates the effect of distance in health care - sometimes now referred to as "Telehealth".

**Ultrasound Scan**

An image created by the use of sound waves above the audible range of the human ear. It is useful in the confirmation of pregnancy, the determination of fetal size and well-being.

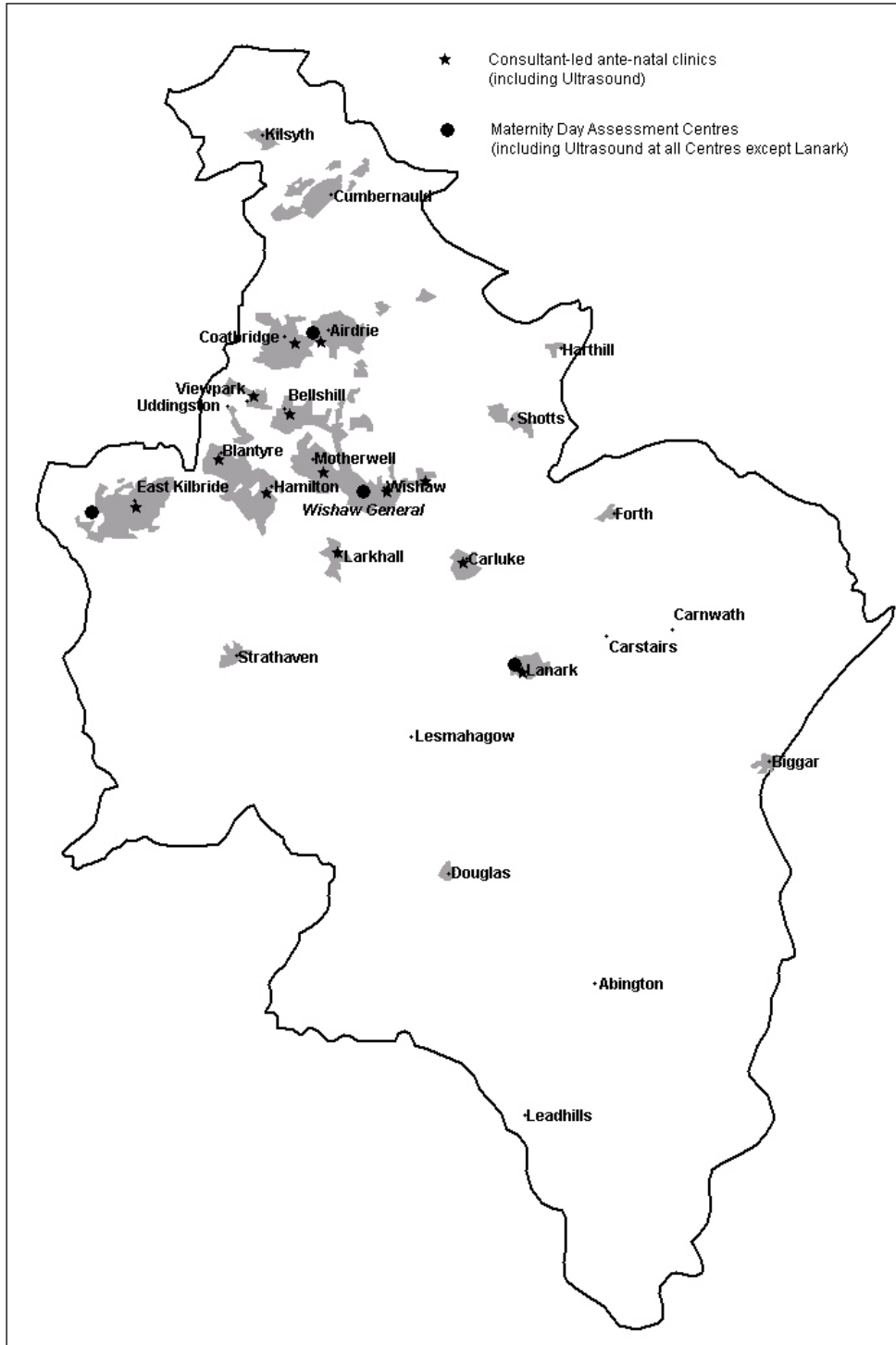
**Woman  
Centered**

The needs of the individual woman provide the focus for the planning, organisation and delivery of maternity services.

**APPENDIX 1****MEMBERSHIP OF STRATEGY WORKING GROUP**

Dr Chris Lennox	Consultant Obstetrician
Mrs Yvonne Bronsky	Maternity Services Manager (until June 2006)
Mrs Susan Stewart	Maternity Services Manager (from Jan 2007)
Mrs Evelyn Frame	Deputy Maternity Services Manager
Lyn Clyde	Community Midwifery Manager
Mrs Carol Prentice	Patient Representative
Dr Charlie Clark	Consultant in Public Health Medicine
Mrs Isobel Frize	Senior Planning Officer

## APPENDIX 2



## APPENDIX 3: WORKFORCE

### **Medical Staffing**

#### *Obstetrics and Gynaecology*

Consultant Obstetricians	13
Associate Specialist and Staff Grade Obstetricians	4
Middle Grade Staff	11
Junior SHOs	17

#### *Neonatal Paediatrics*

Consultant Neonatologists	4.2wte
Staff Grade Neonatologists	2 wte
Middle Grade Neonatology Staff	4
Neonatal SHOs	6

### **Midwifery**

Midwifery Staff	245.26 Wte
Clinical Support Workers	46.38 Wte

### **Other Staff**

Administrative & Clerical Staff

**APPENDIX 4: Neonatal Unit Activity 1999-2006**

<b>Activity</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Admissions	784	867	890	1006	991	964	931	988
Transfers (% of admissions)	70 (8.9)	46 (5.3)	52 (5.8)	42 (4.2)	51 (5.1)	57 (5.9)	66 (7)	66 (6.68)
New Ventilated (NICU)	85	97	103	109	149	119	98	132
NICU Days	582	1086	1250	1350	1503	1389	1757	1183
HDU days	657	952	1235	1482	1209	1649	1972	2740
SCBU days	3658	2898	3364	3414	3984	4040	3842	4136
Deaths	12	15	6	12	20	5	13	11
Low birth weight babies	-	-	-	221	236	237	250	250
Outpatient Visits to NNU	-	-	-	-	665	441	788	549
Intravenous Antibiotics to ward babies	-	-	-	-	514	1578	1274	1430
Resuscitation Calls	-	-	-	-	1649	1325	1034	1072

## APPENDIX 5: PLACE OF BIRTH

### Births to Lanarkshire mothers: 2003-2005

By place of birth

Place of birth	2003	2004	2005
GP Surgery, Kilmarnock	0	0	1
Ayrshire Central Hospital	6	4	13
Borders General Hospital	0	4	1
Inverclyde Royal Hospital	1	0	0
Royal Alexandra Hospital	25	11	16
Forth Park Hospital	0	0	1
Glasgow Royal Infirmary	0	0	1
Princess Royal Maternity Unit	966	1133	1097
Victoria, Glasgow	0	1	0
Southern General Hospital	73	62	78
Queen Mother's Hospital	124	125	129
Raigmore Hospital	0	1	1
Oak Lodge Surgery	1	0	0
Domicillary births, Lanarkshire	48	54	75
Cumbernauld Health Centre	0	1	0
Monklands Hospital	1	1	1
Law Hospital	0	0	1
Hairmyres Hospital	0	3	1
Wishaw General Hospital	4654	4976	4699
Fraserburgh	0	0	1
Dr Gray's Hospital	0	1	0
Domiciliary births, Lothian	0	1	0
St John's Hospital at Howden	57	46	60
New Royal Infirmary of Edinburgh	10	15	17
Ninewells	1	3	8
Falkirk Royal Infirmary	45	0	0
Stirling Royal Infirmary	73	85	89
Cresswell Maternity Hospital	5	4	6
Dumfries & Galloway RI	0	1	0
Total	6090	6532	6296

Source: GRO(S) ISU/NHSL (Ref. Adhoc 20)

**APPENDIX 6: MIDWIFERY PRACTICE DEVELOPMENT REPORT**

Making Practice Perfect

**Practice Development Centre  
Quarterly Report**

**Subject: MIDWIFERY**

**Date: 6/07/06**

**Education Programme Statistics (cumulative from April 2006 to date)**

<b>Course</b>	<b>Places Offered</b>	<b>Places Booked</b>	<b>Actual Attendance</b>
<b>CTG/RISK ASSESSMENT</b>			<b>28</b>
<b>PPH/MATERNAL RESUS</b>	<b>40</b>		<b>53</b>
<b>NEONATAL RESUS</b>	<b>40</b>		<b>60</b>
<b>SHOULDER DYSTOCIA</b>	<b>40</b>		<b>54</b>
<b>PCEA</b>	<b>10</b>		<b>5</b>
<b>PERINEAL REPAIR</b>	<b>30</b>		<b>21</b>
<b>BREAST FEEDING</b>			<b>17</b>

**Education Programme - Comments**

(e.g. Comments on statistics/attendance - cause of discrepancies etc)  
obstetric Emergencies very well attended due to all midwifery managers, unit co-ordinators and 'G' grades attending during the month of June. Due to mat/sickness/Annual leave, only 6 ward sisters still to attend.

**Development Work**

(e.g. Comment on strategic work with which you are involved or other key PD developments)  
Clinical outcome indicators  
Stand & Deliver - midwives presented at the multi-disciplinary meeting in June on the advantages Of mobility in childbirth. Seminar was at full capacity and well received by both midwifery , obstetric and anaesthetic staff. Audit continues. Preliminary figures show an increase of svd rate for the first 6 months of this year by 1% - we hope this will improve.

## **APPENDIX 7: Recommendations of “Building a Health Service fit for the future” (Kerr Report)**

### **Maternity Services**

**90** The work streams of the National Framework for Service Change do not specifically cover maternity services. The S.E. Framework for Maternity Services and reports of the Expert Group on Acute Maternity Services already set a framework to plan and deliver such services across Scotland. However we felt it important to report on progress on implementation and make recommendations for further work.

**91** For the purposes of planning and delivery the “maternity” service includes all the elements of childbearing from pre-conception and antenatal care, preparation for parenthood, through to childbirth, postnatal support, and all aspects of neonatal care. Support throughout these phases is multi-faceted, multi-disciplinary and will be unique to each and every woman and her family. To support the provision of such a service and set a vision and philosophy for these services the Executive produced ‘A Framework for Maternity Services in Scotland’ in 2001 and the reports of the Expert Group on Acute Maternity Services (EGAMS) in 2003.

#### A Framework for Maternity Services in Scotland

**92** The Framework for Maternity Services stated that: ‘Maternity Services should provide a woman and family-centered, locally accessible, midwife managed, comprehensive and effective model of care during pregnancy and child-birth, with clear evidence of joint working between primary, secondary and tertiary services’. The Framework also stresses the importance of evidenced based high quality care; the normality of childbirth and maternity; maternal choice; holistic assessment of needs; person centered care; one-to-one midwifery care in labour; clear pathways of referral within the incremental care pathways of tiered care; support for breastfeeding; clear protocols for comprehensive risk management and assessment; clear communication between clinicians and families and transport issues.

#### The Expert Group on Acute Maternity Services

**93** Following the Framework, the short-life Expert Group on Acute Maternity Services examined the principles of the Framework and how they should be applied to care during childbirth (intrapartum care). The group reviewed the available evidence and agreed that the majority of care should be provided as locally as possible and, that where possible, midwives should be the lead professional for low risk women, but within the appropriate referral pathway and risk management strategy. It suggested core competencies and skills for all maternity professionals at each level of care, and highlighted the importance of a multi-professional, multi-disciplinary, integrated approach to education. Further it highlighted the importance of regional planning in the context of local and national planning, multi-professional working, good communication and IT systems, consumer involvement and transport systems.

**94** The principle conclusion of the Group was that the current configuration of acute maternity services was no longer sustainable and that change was needed. Maternity Services are subject to the same pressures as many other health services that have been brought about by training reconfiguration, recruitment and retention difficulties, changes to contracts and other workforce issues. However, there are a variety of reasons why the current configuration of maternity services is no longer sustainable including significant demographic changes: a decline in birth and fertility rates, reduced family sizes, commencing families at an older age; and changing expectations of all stakeholders, technological advances in care, and parental choice.

### **Current Activity**

#### Regional Planning

**95** Following the publication of EGAMS the Scottish Executive issued funding to each Regional Planning Group to enable them to facilitate real regional planning for maternity services. Given the differing priorities and stages of progress this work has taken a different shape in each of the 3 regions. All 3 regions now have a sub-group for maternity services and are taking forward the implementation of EGAMS through this mechanism. They have been encouraged to work together and across regional boundaries.

#### National Maternity Services Workforce Planning Group

**96** This group was established in 2003 under the chairmanship of Professor Andrew Calder with a multi-professional membership, including regional representatives, national bodies and Royal Colleges. The role of the group is to review the current workforce and service profile, identify gaps, recommend solutions and from this advise and support NHS Boards, Regional Groups and other relevant bodies.

**97** The interim report of the National Group will be published in Spring 2005 and this will set out the current profile of the maternity workforce, including neonatology and anaesthesia, and set out further action taking into account the various drivers for change and emerging models of service delivery.

#### Scottish Multi-professional Maternity Development Programme

**98** EGAMS identified core skills and competencies necessary for all healthcare maternity staff providing intrapartum care in each level of maternity care within the tiered approach, including antenatal, intrapartum, postnatal and neonatal care. In order to achieve these competencies a Maternity Development Programme was established to develop and deliver national evidence based and clinically focussed multi-professional courses. The Programme is managed by the Scottish Multi-professional Maternity Development Group and each course within the Maternity Development Programme is validated by NHS Education for Scotland and accessed via [www.scottishmaternity.org](http://www.scottishmaternity.org).

### **Recommendations For Action**

#### Promoting Normality

**99** Midwives see all women and their families antenatally, during labour and postnatally and have a strong role in ensuring that care throughout pregnancy and beyond is appropriate for each individual case and that choices about birth are properly informed. In order to increase the profile of midwives as lead practitioners for low risk women, midwives should be the first point of contact once a woman thinks or establishes that she is pregnant. In doing this the midwife will take an appropriate history, develop a care plan which focuses on the woman and maximising the opportunities for a normal birth, but in a risk management context and refer to the Obstetrician and Neonatologist as appropriate. Skilled one to one midwifery care in labour increases the opportunities for a woman to have a normal birth and a healthy postnatal period and reduces the need for unnecessary medical intervention.

#### **We recommend that:**

- High quality maternity care should be based on the available evidence about clinically safe and effective practice, and must be woman and baby centered.
- A strong multiprofessional team approach is integral for the delivery of an appropriate seamless maternity services.
- The principles in “A Framework for Maternity Services in Scotland”, especially the tiered and incremental framework for antenatal, intrapartum, postnatal and neonatal care, should be fully implemented.
- The concept of risk assessment and management should be developed at all levels of maternity service provision.
- The role of the midwife as the lead professional in low risk pregnancy, childbirth and puerperium should be promoted and supported.
- One to one maternity care should be the norm in childbirth.

- Community Maternity Units, where deliveries are midwife-led, should be developed, either standalone or co-terminous with a Consultant-led Unit.
- All healthcare maternity professionals should have the appropriate skills and competencies to deliver the appropriate service at each level of care, supported by appropriate communication and explicit referral networks for required incremental care.
- The rates of caesarean section and instrumental vaginal delivery should be regularly audited and reviewed locally and nationally.

### **Maintaining Local Services**

**100** Maternity services should continue to be delivered as locally as possible. It is important to note that the majority of antenatal and postnatal care, and intra-partum care for low risk women is available in the local community but sustainable and more specialist services for childbirth may not be as easy to maintain. There is no such entity as “zero risk” for women who are pregnant and giving birth – an element of risk applies to all pregnancies and all childbirths.

**101** The majority of medical needs of most critically ill newborn babies can be met by the neonatal intensive or high dependency care within most consultant led maternity units. Neonatal surgery and the associated intensive care needs, especially for those babies with complex congenital abnormalities, require specialist surgical and other complex interventions provided by specialist multi-disciplinary teams, which can only be provided in a smaller number of specialist centres.

### **We recommend that:**

- Regional Maternity Planning Groups must be established and maintained.
- Maternity services should be planned regionally with the involvement of all relevant clinical disciplines, the Scottish Ambulance Service and consumers. Some specialist services should be considered nationally.
- Local planning and commissioning of maternity services should take place within this regional context.
- Local and regional referral pathways for increasing levels of all specialist maternity care should be developed.
- Protocols and guidelines for women in labour and specialist neonatal care should be developed.
- New models of service delivery, manpower roles and responsibilities and technological advances should be nationally evaluated and best practice disseminated through communication networks.
- Formal communication and information networks should be developed between all maternity clinicians, both regionally and nationally.
- The configuration of maternity units providing the various levels of intra-partum care should be agreed and developed regionally.
- The configuration of maternity units providing the different levels of neonatal care should be agreed and developed regionally.
- The three Regional Neonatal Transport Services should be developed and maintained to ensure a quick, effective and safe retrieval and transport of neonates to specialist care, when appropriate and required.
- Neonatal surgery and the associated neonatal intensive care requires to be planned and delivered in conjunction with fetal medicine as an integral part of maternity services, taking the configuration of specialist paediatric services into account.

### **National Review of Services**

**102** Local Maternity Services should be subject to on-going review and monitoring subject to the most up to date evidence and best practice. Where necessary national policies should be reviewed and changed in consultation with NHS Boards, Regional Planning Groups and consumers.

**We recommend that:**

- The National Maternity Services Workforce Planning Group should ensure the on-going monitoring of the service and workforce profile and assist Regional Groups to map current and future services.
- The Scottish Executive should continue to review national policy documents, in conjunction with NHS Boards and consumers and identify areas for action.
- Quarterly meetings between the Scottish Executive, NHS Health Scotland, NHS Education for Scotland, NHS Quality Improvement Scotland, National Services ISD and the Scottish Ambulance Service should be arranged to map and monitor national work to support maternity services.

**User Involvement**

**103** Service Users, Voluntary Groups and Communities should all be encouraged to be involved in developing and monitoring maternity services. Locally this is vital as maternity services do not only impact upon the patient (i.e. mother / child) but the wider family.

**We recommend that:**

- The Scottish Executive and NHS Boards should put in place systems to encourage and support user involvements in service development.
- Maternity Service Liaison Committees should be developed and maintained within NHS Boards.
- Women must be informed about risk with unbiased evidence based information to help them decide where to receive care and give birth. Professionals should balance maternal choice, demand and need against assessment of risk and the availability of services.

**Maternity Services Support Group**

**104** A formal, high profile and well established mechanism exists to promote and develop child health and child health services in the form of the Child Health Support Group. This group does not take into account maternity services, although there is a significant overlap with regard to neonatal services, which are an integral part of maternity services.

**We recommend that:**

- A National Maternity Service Support Group should be established  
Or
- The remit of the Child Health Support Group should be extended to include maternity services.